COST AND FINANCIAL REPORTING SYSTEM (CFRS)

Fiscal Year 2006-2007

Local Program Financial Support

Instruction Manual

No text this page.

Manual Order Number:

Specifications contained herein are subject to change and these changes will be reported in subsequent release notes and new editions.

No text this page.

GENERAL CONTACT INFORMATION

By Mail:
Department of Mental Health
Local Program Financial Support
1600 9th St., Room 120
Sacramento, CA 95814

By Telephone or FAX:
916.654.2314 – Cost Report Contact Desk
916.653.9269 – Cost Report FAX
916.654.3117 – IT Help Desk

SPECIFIC CONTACT INFORMATION

If you are having technical problems with the Cost Reporting application and need technical assistance, contact the Cost Report Help Desk at 916.654.2314, or send an email to: cfrs.help@dmh.ca.gov.

If you want to contact a Department of Mental Health Division or Office, please use the Division/Office Directory, located at http://www.dmh.ca.gov.

WEBSITE

The Department of Mental Health, Information Technology Web Services Internet site can be located at https:/mhhitws.cahwnet.gov.

If you are having problems with the website and need technical assistance please go to https://mhhitws.cahwnet.gov/docs/public/contact.asp. This is the direct link to the Contact ITWS section. Users do not need to be logged into ITWS to see contact names, phone numbers and email addresses.

FEEDBACK

If you have any questions or comments concerning the contents of the Department of Mental Health Web site, please use the Feedback Form.

Table of Contents

No text this page.

No text this page.

Getting Started

INTRODUCTION

The Fiscal Year (FY) 2006-2007 Cost Reports and reporting process are described within this section. The cost report is designed to focus on completion of certain schedules that will automatically complete the legal entity cost report forms. The formulas in the cost report forms are "locked and protected" to enable a smoother process for editing and conducting the year-end settlement process for each local mental health agency. This also ensures the ability to create a uniform statewide database. Listed below are the highlights regarding the cost report spreadsheets and cost reporting procedures.

The cost report spreadsheets for this year remain an Excel based spreadsheet application.

There will be two sets of Cost Report spreadsheet automations:

1. **A Detail Cost Report:**

    - To be completed by **all** legal entities (county or contract). Services provided can be either Medi-Cal or non-Medi-Cal.

2. **A Summary Cost Report:**

    - To be completed by each County or Mental Health Plan (MHP).
    - The summary cost report is used to complete certain county only forms.
    - Summarizes each County or MHP total mental health activities for the fiscal year.

The Cost Report automated spreadsheets are available from the Department of Mental Health (DMH) website, at https://mhhitws.cahwnet.gov.

Cost report submission for FY 2006-2007 involves both electronic and hard copies. The electronic submission process involves ***uploading*** the cost report through the Department's Information Technology Web Services (ITWS). The hard copy submission requires one copy of the cost report (summary and county detail only) and an original signed MH1940 certification package ***mailed*** to DMH, by December 31 following the end of the fiscal year.

Please mail to:

Department of Mental Health
Local Program Financial Support
1600 9th Street, Room 120
Sacramento, CA 95814

No text this page.

Summary of Changes

SUMMARY OF CHANGES MADE TO FY 2006-2007
Technical changes, updates, and clarifications have been made to this instruction manual. The following is a summary of the major changes made to the Cost Report for the FY 2006-2007:

1. **MH 1901 Schedule C –** Supporting Documentation for the Method Used to Allocate Total Cost to Mode of Service and Service Function.

   Column E – Eligible Direct Cost
   Non Medi-Cal costs for Modes 45 and 60 may also be entered in this column.

2. **MH 1908 –** Supplemental State Resource Data – Preliminary Worksheet to the MH 1909s.

   Addition of a new funding source:
   4440-104-0001 Mental Health Services AB 3632

3. **MH 1909 –** Supplemental Cost Report Data by Program Category

   Addition of a new MH 1909 to identify SGF allocation and expenditures for:
   4440-104-0001 Mental Health Services AB 3632

   Counties are to continue to complete the MH 1912 – Supplemental Cost Report Data for SEP in addition to the MH 1909 for AB 3632.

4. **MH 1940 –** Year End Cost Report

   Addition of a new funding source:
   4440-104-0001 Mental Health Services AB 3632

5. **MH 1940** – Certification

   The certification language has been modified to reflect MHSA regulations.

   The DMH Only portion located at the bottom of the original certification page has been relocated to the new MH 1940S form.

Cost Report Instructions

The California Department of Mental Health's (DMH) Cost Report is required to be completed by all legal entities furnishing local community mental health (Medi-Cal and non-Medi-Cal) services. For the purpose of year-end cost reporting and submission, each county's designated local mental health agency is required to submit one hard copy of the cost report (summary and county detail only) and an original signed MH1940 certification package to DMH.

The objectives of the DMH Cost Report are to:

- Compute the cost per unit for each Service Function (SF);
- Determine the estimated net Medi-Cal entitlement (Federal Financial Participation (FFP)) for each legal entity;
- Identify the sources of funding;
- Serve as the basis for the local mental health agency's year-end cost settlement, focused reviews and subsequent Short-Doyle/Medi-Cal (SD/MC) fiscal audit; and
- Serve as the source for County Mental Health fiscal year-end cost information.

  This is accomplished by determining the allowable SD/MC costs and allocating these costs, between administrative, utilization review, research and evaluation, and direct service cost centers (i.e., modes of service), including Medi-Cal Administrative Activities (MAA). Participation in the MAA program is optional and requires compliance to additional procedures set by the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), and DMH. Legal entities must have an approved MAA plan with DMH in order to participate in MAA. MAA costs reported in the cost report must be based on actual staff time captured at the service function level.

Direct service costs are apportioned to Medi-Cal patients based on units of service at the service function level. In FY 2006-2007, units of service will continue to be reported according to the period of time during which services were provided. During FY 2006-2007, the federal/state sharing ratio is as follows:

Regular SD/MC:

First Quarter (July 1, 2006 through September 30, 2006)
The FFP sharing ratio for regular Medi-Cal reimbursable mental health treatment services is 50 percent for the federal share and 50 percent for the state share.

Balance of the Fiscal Year (October 1, 2006 through June 30, 2007)
The FFP sharing ratio for regular Medi-Cal reimbursable mental health treatment services is 50 percent for the federal share and 50 percent for the state share.

Enhanced SD/MC (Children) and Healthy Families:

First Quarter (July 1, 2006 through September 30, 2006)
Healthy Families and Enhanced Children's Medi-Cal services are reimbursed at the enhanced FFP reimbursement rate of 65 percent.

Balance of the Fiscal Year (October 1, 2006 through June 30, 2007)
Healthy Families and Enhanced Children's Medi-Cal services are reimbursed at the enhanced FFP reimbursement rate of 65 percent.

Enhanced SD/MC (Refugees)

All Quarters (July 1, 2006 – June 30, 2007)
The FFP sharing ratio for Enhanced SD/MC (Refugees) is 100 percent for the entire year.

SD/MC Administration, Quality Assurance/Utilization Review and MAA

The FFP sharing ratio for Skilled Professional Medical Personnel (SPMP) engaged in quality assurance oversight is 75 percent federal share and 25 percent state share. Other quality assurance costs and all other administrative costs, including MAA, is 50/50 percent sharing ratio.

The enhanced FFP reimbursement rate for Healthy Families Administration is currently 65 percent.

After units of service are identified as described above, SD/MC service function costs are aggregated into inpatient and outpatient costs. Aggregate direct services SD/MC costs (including regular SD/MC, Medicare/Medi-Cal crossover, Enhanced SD/MC for children and refugees) for inpatient and outpatient services for each legal entity are compared with aggregate Medi-Cal published charges and the aggregate Statewide

Maximum Allowances (SMA) reimbursement amounts to determine the direct service reimbursement methodology based on the Lower of Cost or Charge (LCC) principles. This reimbursement methodology is applied to all SD/MC aggregated costs listed above. For negotiated rate legal entities, SD/MC direct service reimbursement is based on the lower of the aggregate SD/MC negotiated rates for inpatient and outpatient services, the aggregate published charges, or the aggregate SMA reimbursement. Patient and other payor liabilities collected on behalf of regular SD/MC, Medicare/Medi-Cal crossover, and enhanced SD/MC patients, are reduced from the gross direct service reimbursement for SD/MC to determine the net due for SD/MC direct services.

Healthy Families direct service costs are NOT included in the calculation to determine the SD/MC reimbursement methodology based on the LCC. However, the Healthy Families costs are aggregated and compared in the same way as SD/MC direct services costs and utilizes the same reimbursement methodology determined by the SD/MC costs. Gross direct service reimbursement Healthy Families costs are reduced by patient and other payor liabilities of Healthy Families clients to determine the net Healthy Families reimbursement for direct services.

SD/MC administrative reimbursement for county legal entities is based on the SD/MC direct service reimbursement in the county.[1] Reimbursement for SD/MC utilization review activities also is computed. The sum of net SD/MC direct service reimbursement, net MAA reimbursement, SD/MC administrative reimbursement, and SD/MC utilization review reimbursement represents the basis for determining the preliminary FFP for legal entities' cost based reimbursement. Legal entities reimbursed based on negotiated rates must subtract 25 percent of the amount negotiated rates exceed costs.

Contract providers that provide services to multiple counties have the option to complete the cost report in one of two ways. The first method, "Total Gross Costs," allows the contractor to report its total gross costs for mental health related services provided to multiple counties on MH 1960 and make adjustments on Line 2 of MH 1992 for each county cost report to eliminate costs not related to the county in order to properly show the funding source for services provided to the county. The second method, "Net Cost," allows the contractor to report only the costs (activities) of the legal entity that are identified with each county. The use of any one method will produce the same result, and each county has the discretion to select the method to be used by its contractors. Round amounts to the nearest whole dollar.

Use the following procedures to complete the Department of Mental Health fiscal year-end Cost Report.

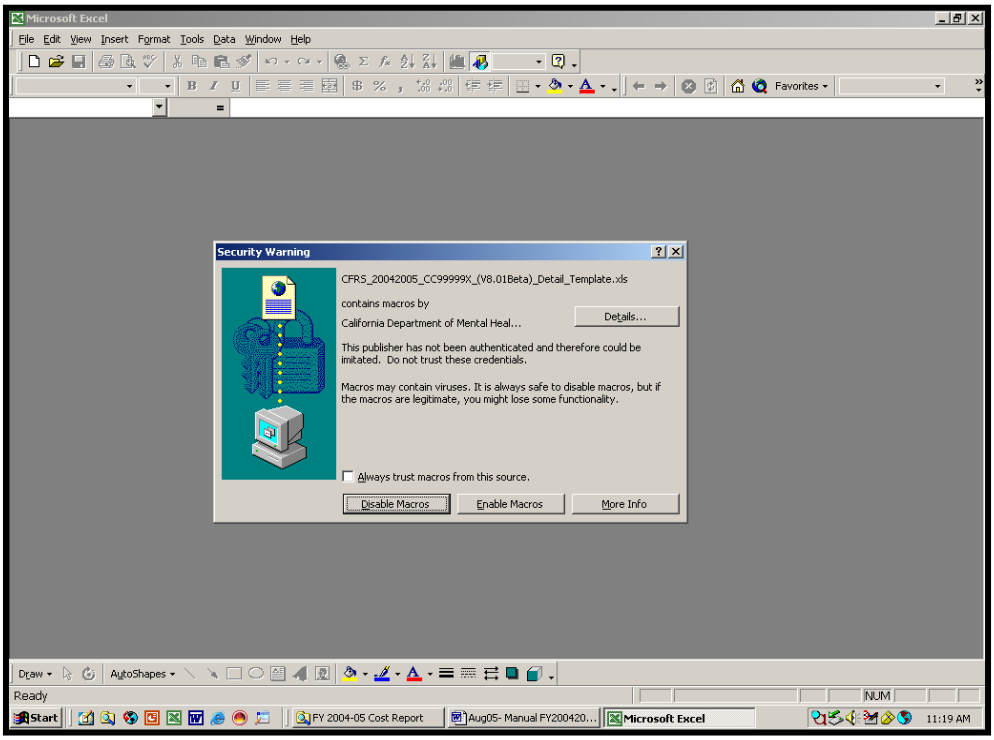
[1] Throughout these instructions, county legal entities are defined as legal entities staffed and operated by county government employees.

No text this page.

Opening the Workbook

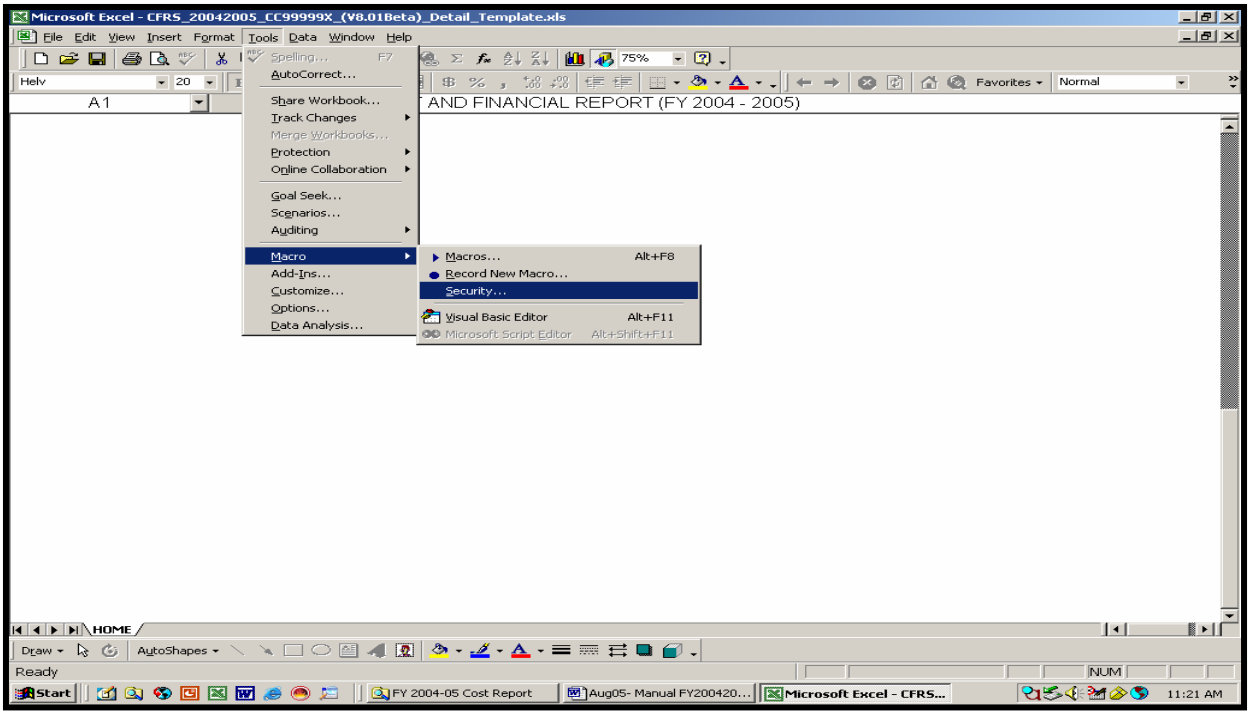
Enable the Macros

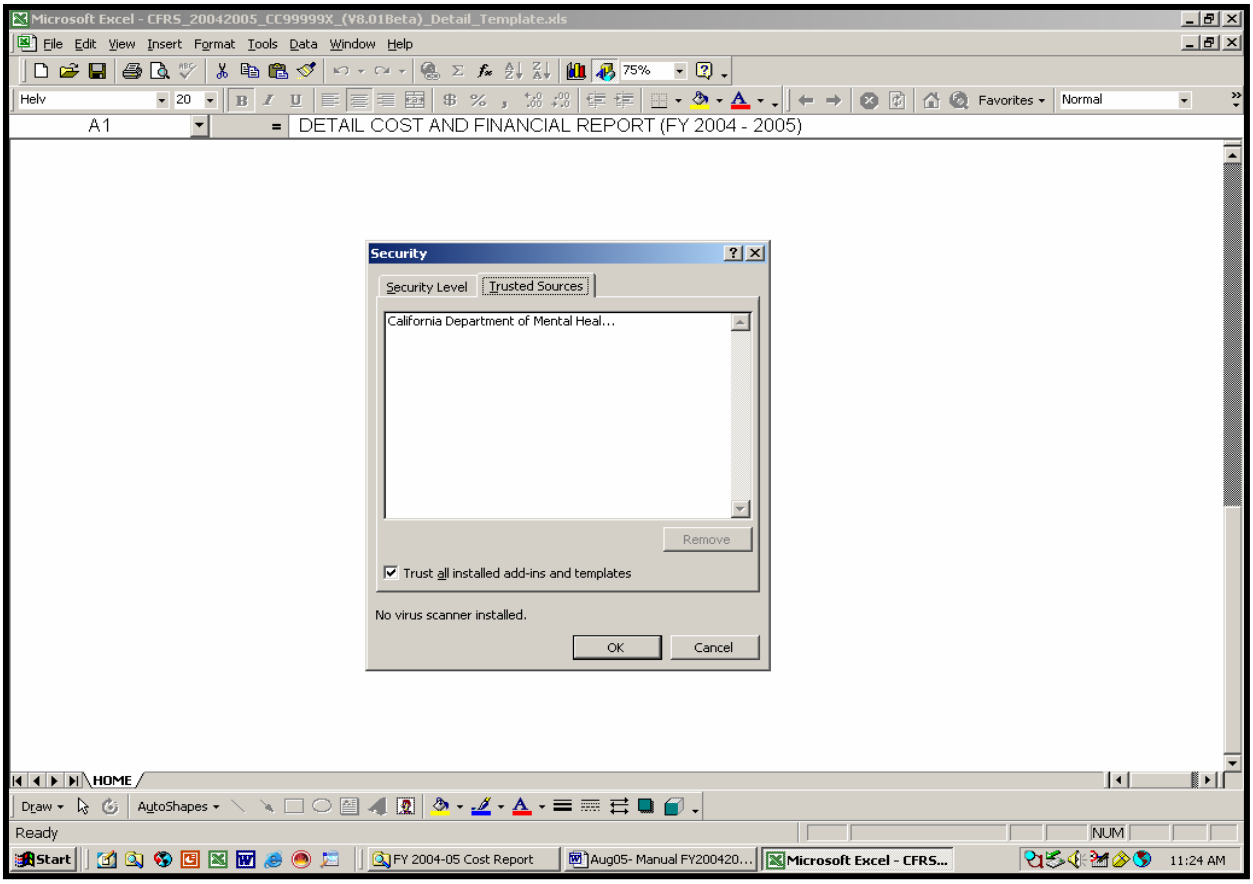
The Cost Report is an Excel based application. It uses macros that enable the flow and automatic population for most of the forms. When the workbook is first opened, a dialog window appears and asks whether or not to allow this functionality. **You must check "Always trust macros from this source"** if you do not want to see this dialog window again when opening the Cost Report template.



If you trust DMH Information Technology and prefer to **ENABLE MACROS** every time you work on the Cost Report template but have accidentally checked "Always trust macros from this source" you can restore the dialog window back by following these procedures. **TOOLS > MACRO > SECURITY > TRUSTED SOURCES.** In the Trusted Sources Dialog box, click on Department of Mental Health…and click on **REMOVE** to restore back the window.

Please note the above form reflects FY 2004-2005.





REMOVE to restore "**Always trust macros from source**" Dialog Box window.

Please note the above forms reflect FY 2004-2005.

HOME

Cost Report Home Page

After you have opened the workbook and enabled the macros, you will now be at the Cost Report Home Page.

From here, you can continue to complete the cost report, or use some of the other options of the cost report.

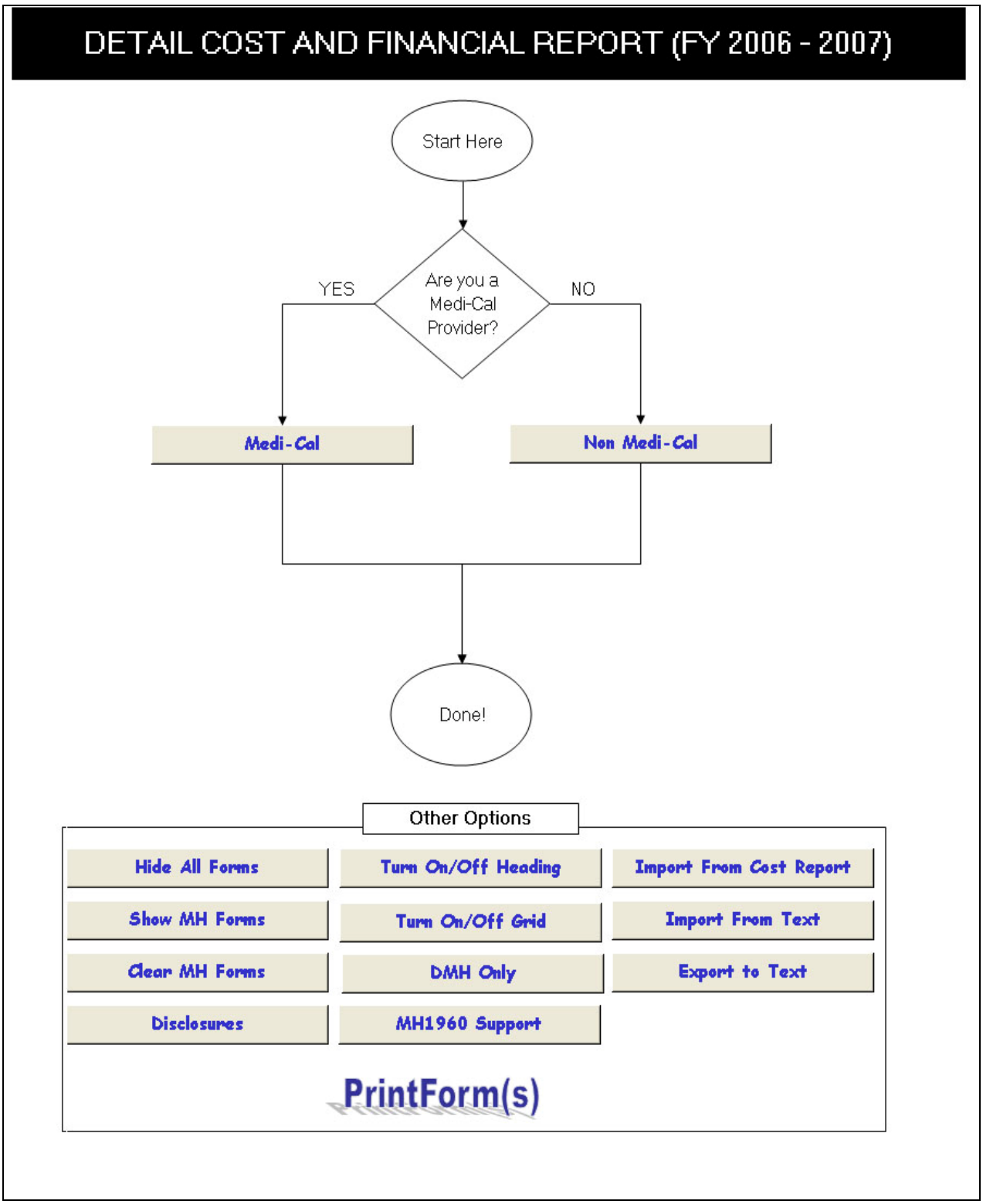
If you wish to continue to complete the cost report, simply "click" on the button for MEDI-CAL or NON-MEDI-CAL, depending upon type of cost report that you are trying to complete.

Subsequently, you will be shown a series of "flowcharts" from your chosen action.

NOTE: The **OPTIONS** box, at the bottom of the HOME Page Sheet, allows you to do the following:

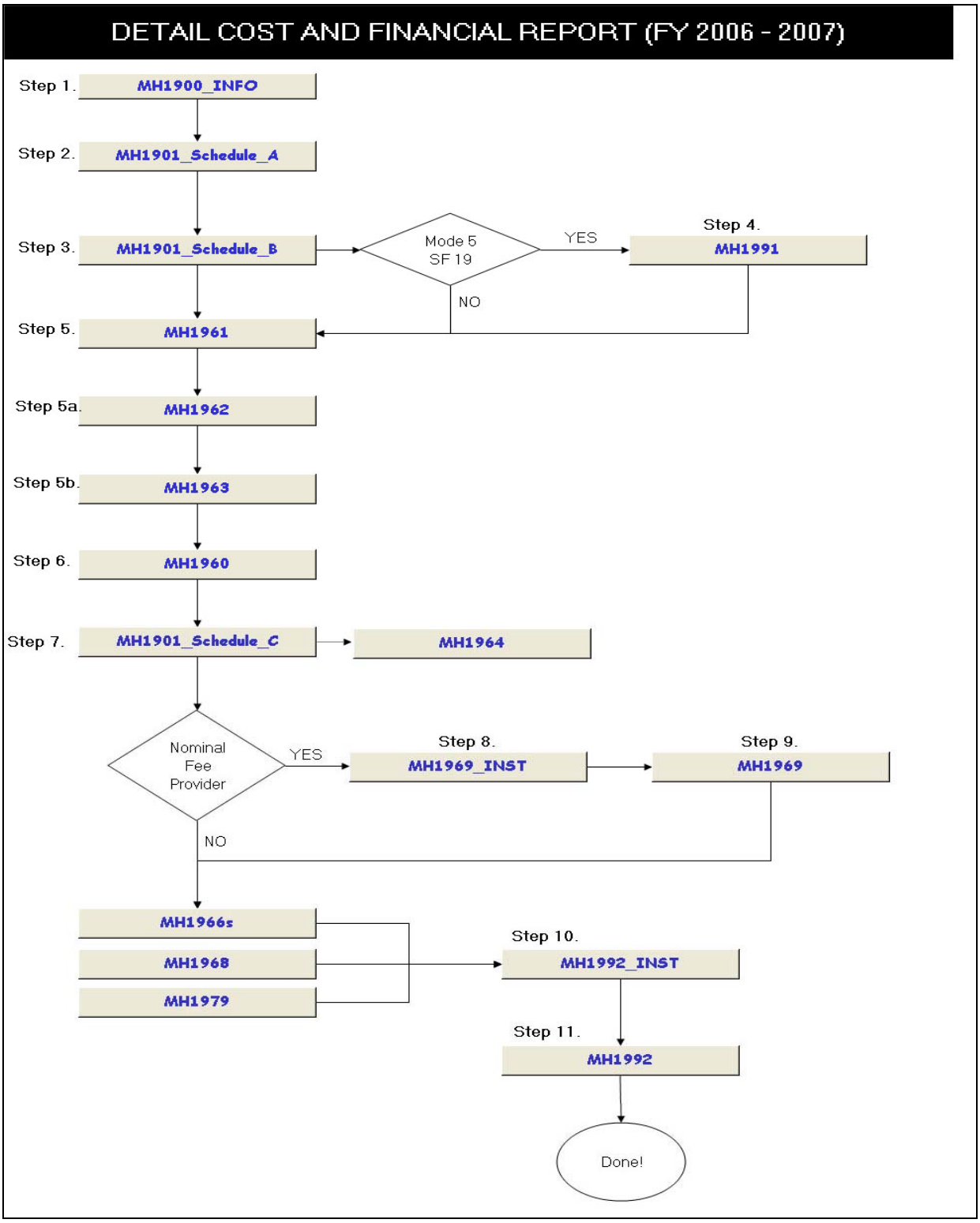
Options Described:

Hide All Forms	Shows only the Home page.
Show MH Forms	Shows all the Cost Report worksheets.
Clear Forms	Reset all data values in forms to zeros or blanks.
Turn On/Off Heading	Toggles the Excel Row and Column indicators, such as A, B, C, and 1, 2, 3, etc. Useful if only wanting to see FORM Row and Column indicators and NOT EXCEL Row and Column indicators.
Turn On/Off Grid	Toggle the Excel background grid showing cell placement.
Import from Cost Report	This option will allow you to import from another DMH Cost Report workbook data into the current workbook. These cost reports must be from the same fiscal year.
Import from Text	This option will allow you to import and populate data into the MH_Schedules.
Export to Text	This option will allow you to export the data from the MH_Schedules.
Print Options	This option will allow you to print selected schedules or forms of the cost report.


DETAIL COST AND FINANCIAL REPORT (FY 2006 - 2007)
Start Here
Are you a Medi-Cal Provider?
YES
NO
Medi-Cal
Non Medi-Cal
Done!
Other Options
Hide All Forms
Turn On/Off Heading
Import From Cost Report
Show MH Forms
Turn On/Off Grid
Import From Text
Clear MH Forms
DMH Only
Export to Text
Disclosures
MH1960 Support
PrintForm(s)

MEDI-CAL

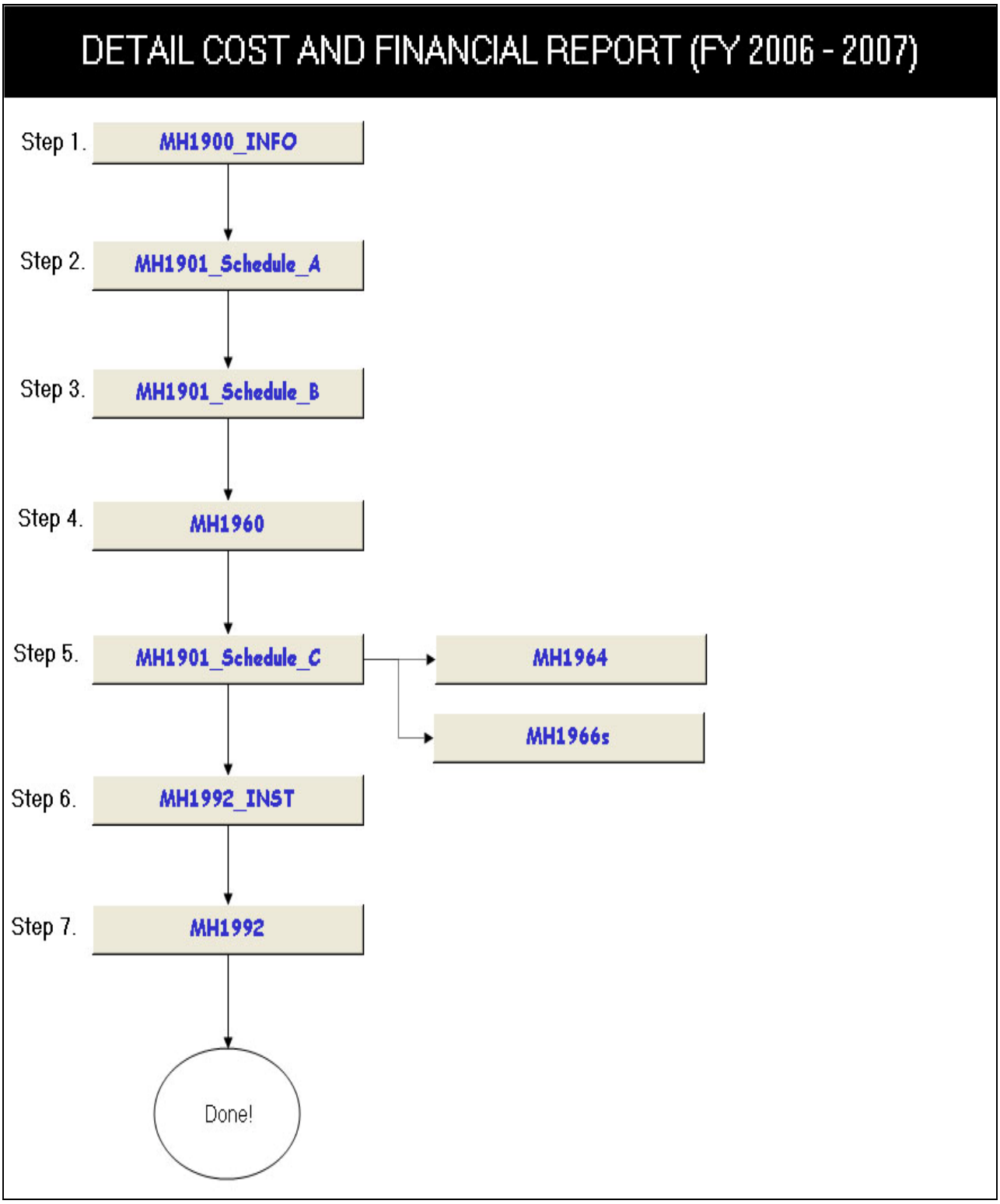
Flowchart Path if Medi-Cal Cost Report


DETAIL COST AND FINANCIAL REPORT (FY 2006 - 2007)
Step 1.
MH1900_INFO
Step 2.
MH1901_Schedule_A
Step 3.
MH1901_Schedule_B
Mode 5
SF 19
YES
Step 4.
MH1991
NO
Step 5.
MH1961
Step 5a.
MH1962
Step 5b.
MH1963
Step 6.
MH1960
Step 7.
MH1901_Schedule_C
MH1964
Nominal
Fee
Provider
YES
Step 8.
MH1969_INST
Step 9.
MH1969
NO
MH1966s
MH1968
MH1979
Step 10.
MH1992_INST
Step 11.
MH1992
Done!

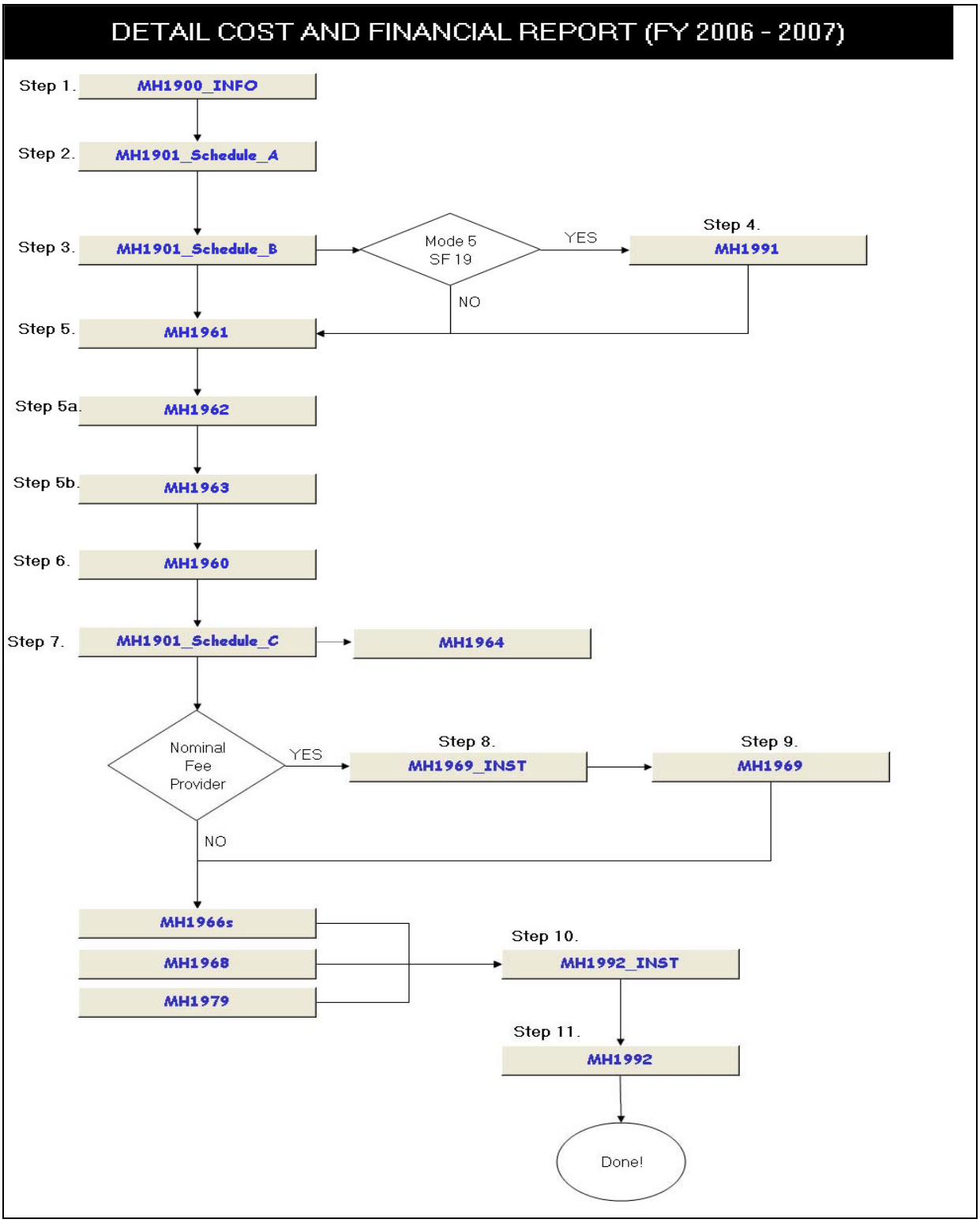
MEDI-CAL

Non-MEDI-CAL

Flowchart Path if Non-Medi-Cal Cost Report


DETAIL COST AND FINANCIAL REPORT (FY 2006 - 2007)
Step 1.
MH1900_INFO
Step 2.
MH1901_Schedule_A
Step 3.
MH1901_Schedule_B
Step 4.
MH1960
Step 5.
MH1901_Schedule_C
MH1964
MH1966s
Step 6.
MH1992_INST
Step 7.
MH1992
Done!

NON-MEDI-CAL


DETAIL COST AND FINANCIAL REPORT (FY 2006 - 2007)
Step 1.
MH1900_INFO
Step 2.
MH1901_Schedule_A
Step 3.
MH1901_Schedule_B
Mode 5
SF 19
YES
Step 4.
MH1991
NO
Step 5.
MH1961
Step 5a.
MH1962
Step 5b.
MH1963
Step 6.
MH1960
Step 7.
MH1901_Schedule_C
MH1964
Nominal
Fee
Provider
YES
Step 8.
MH1969_INST
Step 9.
MH1969
NO
MH1966s
MH1968
MH1979
Step 10.
MH1992_INST
Step 11.
MH1992
Done!

Detail Forms for ALL Legal Entities

This section details the following forms and their requirements for ALL Legal Entities. This includes county and contract legal entities.

MH 1900	Information Worksheet
MH 1901 Schedule A	Statewide Maximum Allowances, Negotiated Rates and Published Charges
MH 1901 Schedule B	Worksheet for Units of Service and Revenues by Mode and Service Function
MH 1901 Schedule C	Supporting Documentation for the Method Used to Allocate Totals to Mode of Service and Service Function
MH 1960	Calculation of Program Costs
MH 1961	Medi-Cal Adjustments to Costs
MH 1962	Other Adjustments
MH 1963	Payments to Contract Providers
MH 1964	Allocation of Costs to Modes of Service
MH 1966 (Program 1 and Program 2)	Allocation of Costs to Service Functions – Mode Total
MH 1966 (Mode 05, Service Function 19)	EXCEPTION (Mode 05, Service Function 19)
MH 1966 (Modes 45 and 60)	Allocation of Costs to Service Functions – Mode Total for Outreach and Support (Modes 45 and 60)
MH 1966 (Mode 55)	Allocation of Costs to Service Functions – Mode Total for Mode 55 Medi-Cal Administrative Activities (MAA)
MH 1968	Determination of SD/MC Direct Services and MAA Reimbursement
MH 1969 (Optional)	Lower of Costs or Charges Determination
MH 1979	SD/MC Preliminary Desk Settlement
MH 1991	Calculation of SD/MC (Hospital Administrative Days)
MH 1992	Funding Sources

MH 1900

Information Worksheet

The Information Worksheet is the starting point for the completion of the automated SD/MC Cost Report. The information provided here is automatically linked to forms and schedules in the cost report. This worksheet eliminates the redundant entry of county name and code, legal entity name and number on cost report forms and schedules. The information provided here applies to county and contract legal entities for Medi-Cal and non-Medi-Cal Cost Reports.

The Information Worksheet is divided into sections. Section I should be completed by "All Legal Entities" and Section II should be completed by "County Legal Entities only."

Section I: All Legal Entities
Legal entities that provided SD/MC units of service during the reporting period should select the "Y" option to the question, "Are you reporting SD/MC?" If you are not reporting SD/MC units of service, select option "N".

Section II: County Legal Entity Only
Each county legal entity is required to respond to the question whether their population is either over or under 125,000 population. If county population is over 125,000, select option "Y". If it is either 125,000 or under, select option "N".

County legal entities should report "Contract Provider Medi-Cal Direct Service Gross Reimbursement". The amount reported here is used to populate MH 1979, Line 2, Columns B and C used for the determination of Medi-Cal Administrative Reimbursement Limit.

NOTE: The reported amount is the sum of MH 1968, Lines 21, 21A and 22, Columns E & K for all Contract Providers that reported Medi-Cal units on the MH 1901 Schedule B. (Refer to MH 1979, Line 2 for details.)

County legal entities should report "Contract Provider Healthy Families Direct Service Gross Reimbursement". The amount reported here is used to populate MH 1979, Line 7A, Columns B and C, which are used for the determination of Healthy Families Administrative Reimbursement Limit.

NOTE: The reported amount is the sum of MH 1968, Lines 27 and 27A, Columns E & K for all Contract Providers that reported Healthy Families units on MH 1901 Schedule B.

County legal entities also are required to enter the provider numbers for Fee-For-Service Mental Health Specialty for individual and group providers.

County legal entities can make adjustments to Medi-Cal FFP due to contract limitations that will automatically populate MH 1979, Line 22, Column J.

State of California Health and Human Services Agency — Department of Mental Health

DETAIL COST REPORT
INFORMATION SHEET
MH1900 (Rev. 7/06) — FISCAL YEAR 2006 - 2007

SECTION I: ALL LEGAL ENTITIES:

All Legal Entities are to complete Section I.

Name of Preparer:	
Date:	
Legal Entity Name:	
Legal Entity Number:	
County:	
County Code:	
Is this a County Legal Entity Report? (Y or N)	Yes
Are you reporting SD/MC? (Y or N)	Yes

HOME MH1901_Schedule_A >>

SECTION II: COUNTY LEGAL ENTITY ONLY:

Only County Legal Entities are to Complete Section II.

Address:	
Phone Number:	
County Population: Over 125,000? (Y or N):	Yes

Contract Provider Medi-Cal Direct Service Gross Reimbursement (Used to populate MH1979 Line 2)

Inpatient Services	
Outpatient Services	

Contract Provider Healthy Families Direct Service Gross Reimbursement (Used to populate MH1979 Line 7)

Inpatient Services	
Outpatient Services	

Total State Share of SD/MC Cost:	

Fee For Service - Mental Health Specialty Provider Numbers For Individual and Group — *Mode&SF -->*

Legal Entity Number (FFS):	
Psychiatrist:	
Psychologist:	
Mixed Specialty Group:	
RN:	
LCSW:	
MFCC (MFT):	

Adjust Medi-Cal FFP Due to Contract Limitation (Used to populate MH1979 Line 22J)

Mode 05 - Hospital Inpatient Services	
Mode 05 - Other 24 Hour Services	
Mode 10 - Day Services	
Mode 15 - Outpatient Services	
Contract Limitation Adjustment Total	$ -

HOME MH1901_Schedule_A >>

MH 1901 Schedule A

Statewide Maximum Allowances, Negotiated Rates and Published Charge

MH 1901 Schedule A requires information on state-approved Negotiated Rates (NR) and Published Charges (PC) for all authorized services. The form layout is by Mode and Service Functions (SF) and includes the FY 2006-2007 SD/MC Statewide Maximum Allowances (SMA). While the SMA rates are provided, each legal entity must input the NR and PC data for all authorized services. This form serves as a "source document" that will enable the SMA, NR and PC rates to be cell referenced to other applicable MH forms.

Column D – Negotiated Rate (NR)
Enter the Negotiated Rates for all Modes and Service Functions that have State-approved rates.

Column E – Published Charge (PC)
Enter Published Charge rates for appropriate Modes and Service Functions reported. Note that Outreach (including MAA) and Support Services are excluded. A legal entity's published charge is: (1) the usual and customary charge to the general public's "published charges" are usual and customary charges prevalent in the public mental health sector that are used to bill the general public, insurers, or other non-Medi-Cal payors. Legal entities with more than one published charge rate for a service function can report a *weighted average* published charge rate for the service function, or provide a separate support schedule with the following information: (1) each service function; (2) time period covered by each published charge; (3) each published charge per unit of service; (4) Medi-Cal units of service provided for each published charge; (5) total published charges for each service function (published charge per unit multiplied by the units of service). The published charge for Mode 05, Service Function 19, Hospital Administrative Days, should include physician and ancillary costs.

Column E, Rows 31-35 – Medi-Cal Eligibility Factor
Enter the Medi-Cal Eligibility Factor if participating in Medi-Cal Administrative Activities (MAA). A separate eligibility factor should be reported for each quarter claimed and should be consistent with quarterly MAA invoices submitted to DMH.

Column F, County Non-Medi-Cal Contract Rate
Enter the non-Medi-Cal contract rates agreed between county and its service providers for Modes 45 and 60. Do not enter Medi-Cal contract rates in this column.

Column G, Rate for Allocation
This column carries forward the NRs, entered in Columns D and F (county non-Medi-Cal contract rates with service providers), to the appropriate MH 1966 for the purpose of allocating costs to modes and service functions.

State of California Health and Human Services Agency — Department of Mental Health

DETAIL COST REPORT

SCHEDULE OF STATEWIDE MAXIMUM ALLOWANCES, NEGOTIATED RATES AND PUBLISHED CHARGES

MH 1901 SCHEDULE A (Rev. 7/07) FISCAL YEAR 2006 - 2007

Entity Name: 0 Entity Number: _____

Fiscal Year: 2006 - 2007

		A	B	C	D	E	F	G
	SERVICE FUNCTION	MODE	SERVICE FUNCTION CODE	SMA	STATE APPROVED (NR)	PUBLISHED CHARGE	COUNTY NON M/C CONTRACT RATE	RATE FOR ALLOCATION
	A. 24 - HOUR SERVICES							
1	Hospital Inpatient	05	10 - 18	$995.74				$0.00
2	Hospital Administrative Day	05	19	$309.76				$0.00
3	Psychiatric Health Facility (PHF)	05	20 - 29	$540.08				$0.00
4	SNF Intensive	05	30 -34					$0.00
5	IMD Basic (No Patch)	05	35					$0.00
6	IMD (With Patch)	05	36 - 39					$0.00
7	Adult Crisis Residential	05	40 - 49	$304.55				$0.00
8	Jail Inpatient	05	50 - 59					$0.00
9	Residential Other	05	60 - 64					$0.00
10	Adult Residential	05	65 - 79	$148.55				$0.00
11	Semi - Supervised Living	05	80 - 84					$0.00
12	Independent Living	05	85 - 89					$0.00
13	MH Rehab Centers	05	90 - 94					$0.00
	B. DAY SERVICES							
14	Crisis Stabilization Emergency Room	10	20 - 24	$94.54				$0.00
15	Urgent Care	10	25 - 29	$94.54				$0.00
16	Vocational Services	10	30 - 39					$0.00
17	Socialization	10	40 - 49					$0.00
18	SNF Augmentation	10	60 - 69					$0.00
19	Day Treatment Intensive Half Day	10	81 - 84	$144.13				$0.00
20	Full Day	10	85 - 89	$202.43				$0.00
21	Day Rehabilitation Half Day	10	91 - 94	$84.08				$0.00
22	Full Day	10	95 - 99	$131.24				$0.00
	C. OUTPATIENT SERVICES							
23	Case Management, Brokerage	15	01 - 09	$2.02				$0.00
24	Mental Health Services	15	10 - 19	$2.61				$0.00
25	Mental Health Services	15	30 - 59	$2.61				$0.00
26	Medication Support	15	60 - 69	$4.82				$0.00
27	Crisis Intervention	15	70 - 79	$3.88				$0.00
	D. OUTREACH SERVICES							
28	Mental Health Promotion	45	10 - 19					$0.00
29	Community Client Services	45	20 - 29					$0.00
	E. MEDI-CAL ADMINISTRATIVE ACTIVITIES				**MEDI-CAL ELIGIBILITY FACTOR**			
30	Medi-Cal Outreach	55	01 - 03					
31	Medi-Cal Eligibility Intake	55	04 - 06		Quarter 1			
32	Medi-Cal Contract Administration	55	07 - 08		Quarter 2			
33	MAA Coordination and Claims Administration	55	09		Quarter 3			
34	Referral - Crisis, Non-Open Case	55	11 - 13		Quarter 4			
35	MH Services Contract Administration	55	14 - 16		Average			
36	Discounted Mental Health Outreach	55	17 - 19					
37	SPMP Case Management, Non-Open Case	55	21 - 23					
38	SPMP Program Planning and Development	55	24 - 26					
39	SPMP MAA Training	55	27 - 29					
40	Non-SPMP Case Management, Non-Open Case	55	31 - 34					
41	Non-SPMP Program Planning and Development	55	35 - 39					
	F. SUPPORT SERVICES							
42	Conservatorship Investigation	60	20 - 29					$0.00
43	Administration	60	30 - 39					$0.00
44	Life Support/Board & Care	60	40 - 49					$0.00
45	Case Management Support	60	60 - 69					$0.00
46	Client Housing Support Expenditures	60	70					$0.00
47	Client Housing Operating Expenditures	60	71					$0.00
48	Client Flexible Support Expenditures	60	72					$0.00
48	Non Medi-Cal Capital Assets	60	75					$0.00
48	Other Non Medi-Cal Client Support Expenditures	60	78					$0.00

HOME << MH1900_INFO MH1901_Schedule_B >>

MH 1901 Schedule B

Worksheet for Units of Service and Revenues by Mode and Service Function

MH 1901 Schedule B is an "all purpose" type worksheet. Data reported here is used to populate the MH 1966, MH 1968, and MH 1979. This worksheet identifies services according to "settlement type", modes and service functions and the period of service. ***You will be prompted to fill out MH 1991 if you report Mode 05, Service Function 19.***

Total units of service and units allocated to SD/MC, Medicare/Medi-Cal Crossovers, Enhanced Medi-Cal, Medi-Cal Administrative Activities and Healthy Families are accounted for here. Total units reported must equal the sum of Columns G, J, M, N, P, R, S and U. Patient and Other Payor Revenues must also be reported on this worksheet. If unable to isolate Patient and Other Payor Revenues at the service function level, revenues can be reported at the modes of service level under the first reported service function within each mode.

SD/MC EXPLANATION OF BALANCES (EOB) AND INTERNAL REPORTING SYSTEM

The SD/MC system pays for mental health services provided under the SD/MC program to Medi-Cal beneficiaries. This system supports the claims submission, correction, and approval processes for the counties. For cost report submission and reconciliation, unit of service data reported must match Explanation of Balances (EOB) records and internal reporting system available in the county to track SD/MC units and revenues that were approved and valid.

NOTE: Complete reliance on the EOB reports is not sufficient because some approved claims, later denied, cannot be edited from the EOB reports. It is mandatory that the county establishes an internal tracking system that accurately complements the EOB reports for both cost report submission and audit trail purposes. Separate tracking systems labeled ***package A, and package B*** must be used to account for SD/MC units of service reported for year-end cost report submission and final cost report reconciliation. Package A should contain EOB SD/MC unit of service data used for year-end cost report submission, and package B should contain EOB SD/MC units of service data for final cost report reconciliation. These records should be maintained along with other records for cost report settlement and audit purposes.

Column A – Settlement Type
Enter the settlement type (CR, NR, TBS, ASO, MAA, MHS, ISA and CAW) in Column A. Settlement type identifies the method used to determine reimbursement limit due to application of each program's rules and regulations or as part of a performance agreement between the Department and county legal entities.

State of California Health and Human Services Agency — Department of Mental Health

DETAIL COST REPORT

WORKSHEET FOR UNITS OF SERVICE AND REVENUE BY MODE AND SERVICE FUNCTION

MH 1901 SCHEDULE B (Rev. 7/06) — FISCAL YEAR 2006 - 2007

Entity Name: 0 Entity Number:

Fiscal Year: 2006 - 2007

Settlement Types		
	CR - Cost Reimburse	MAA - Medi-Cal Administrative Activities
	NR - Negotiated Rate	MHS - Mental Health Specialty
	TBS - Therapeutic Behavioral Services	ISA - Integrated Service Agency
	ASO - Administrative Services Organization	CAW - CALWORKS Services

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
					SD/MC DATA			MEDICARE/MEDI-CAL CROSSOVER DATA			MEDI-CAL PATIENT AND OTHER PAYOR REVENUE		ENHANCED SHORT DOYLE MEDI-CAL DATA					HEALTHY FAMILIES (SED) DATA				
	Settlement Type	Mode	SF	Total Units of Service	Units 07/01/06 - 09/30/06	Units 10/01/06 - 06/30/07	Total Units	Units 07/01/06 - 09/30/06	Units 10/01/06 - 06/30/07	Total Medicare/ SD/MC Crossover Units	07/01/06 - 09/30/06	10/01/06 - 06/30/07	Units 07/01/06 - 09/30/06 (Children)	Units 10/01/06 - 06/30/07 (Children)	3rd Party Revenue (Children)	Units (Refugees)	3rd Party Revenue (Refugees)	Units 07/01/06 - 09/30/06	Units 10/01/06 - 06/30/07	3rd Party Revenue	Non Medi-Cal Units
1																					
2																					
3																					
4																					
5																					
6																					
7																					
8																					
9																					
10																					
11																					
12																					
13																					
14																					
15																					
16																					
17																					
18																					
19																					
20																					
21																					
22																					
23																					
24																					
25																					
26																					
27																					
28																					
29																					
30																					
31																					
32																					
33																					
34																					
35																					
67																					
68																					
69																					
70																					
71																					
72																					
73																					
74																					
75																					
76																					
77																					
78																					
79																					
80																					
81																					
82																					
83																					
84																					
Totals																					

HOME | << MH1901_Schedule_A | MH1961 >> MEDI-CAL ADJUSTMENTS TO COSTS | MH1962 >> OTHER COSTS | MH1963 >> PAYMENT TO CONTRACT PROVIDERS | MH1960 >> CALCULATION OF PROGRAM COSTS

- **CR** Cost Reimbursement (CR) method of reimbursement is based on actual cost.

- **NR** Negotiated Rate (NR) method of reimbursement is based on a negotiated rate approved by the State.

- **TBS** Therapeutic Behavioral Services (TBS) are individual or group providers, and organizational providers that contract with county Mental Health Plans (MHPs) to provide *TBS ONLY* services. These providers are not required to submit annual cost reports to the State. County MHPs should reimburse this provider type and report these costs to DMH as actual costs to the county under the county legal entity number (detailed cost report) in Program 2 – TBS costs. *(Note: cost reports from organizational providers that provide TBS ONLY services will not be accepted. However, LE's providing TBS ONLY services are required to complete a cost report.)*

- **ASO** Administrative Services Organization (ASO) method of reimbursement is actual cost to the county. Counties are allowed to claim actual costs for payments made to the fiscal intermediary for the provision of services and related administrative fees for children placed outside of the county.

- **MAA** Medi-Cal Administrative Activities (MAA) method of reimbursement is based on actual costs to the county for counties participating in mental health MAA. Participation includes submission of a claiming plan, state and federal level approval of a County Mental Health MAA Plan and the submission of invoices through DMH during the year. All MAA invoices must be submitted by the time the cost report is due, and the units of service identified on the cost report must match the invoiced units. Please contact your MAA Coordinator for additional participation requirements.

- **MHS** Mental Health Specialty (MHS) method of reimbursement is actual cost to the county. Counties are allowed to claim actual costs for payments made to Fee-For-Service individual or group providers for mental health specialty services.

- **ISA** Integrated Service Agency (ISA) method of reimbursement is based on actual costs to the county for payments made to the providers of ISA services.

- **CAW** California Work Opportunity and Responsibility to Kids (CalWORKS) program is to prepare clients for work and assist them to obtain and maintain employment so they can effectively support their families. Under CalWORKS, case aid to families is time-limited and able-bodied adults in the families must meet certain work requirements to remain eligible. County welfare departments under the supervision of California Department of Social Services (CDSS) administer this program.

Column B – Mode
Enter the mode of service.

Column C – Service Function
Enter the service function.

Column D – Total Units of Service
Enter the total units for each service function.

Column E – SD/MC Units
(July 1, 2006 – September 30, 2006)
Enter the total regular SD/MC units (from billing records) for each Medi-Cal service function for the period 07/01/06-09/30/06. Do not include Medicare/Medi-Cal crossover units or enhanced SD/MC units here.

Column F – SD/MC Units
(October 1, 2006 – June 30, 2007)
Enter the total regular SD/MC units (from billing records) for each Medi-Cal service function for the period 10/01/06-06/30/07. Do not include Medicare/Medi-Cal crossover units or enhanced SD/MC units here.

Column G – Total SD/MC Units
No entry. This column sums Columns E and F.

Column H – Medicare/Medi-Cal Crossover Units
(July 1, 2006 – September 30, 2006)
Enter the Medicare/Medi-Cal Crossover units by service function for the period 07/01/06-09/30/06.

Column I – Medicare/Medi-Cal Crossover Units
(October 1, 2006 – June 30, 2007)
Enter the Medicare/Medi-Cal Crossover units by service function for the period 10/01/06-06/30/07.

Column J – Total Medicare/Medi-Cal Crossover Units
No entry. This column sums Columns H and I.

Columns K & L – Third Party Revenue for Patient and Other Payors
Enter the 3rd party revenue received by the agency and attributed to regular SD/MC and Medicare/Medi-Cal crossover units of service (07/01/06-09/30/06) for each service function or mode of service. Enter the 3rd party revenue received by the agency and attributed to regular SD/MC and Medicare/Medi-Cal crossover units of service (10/01/06-06/30/07) for each service function or mode of service.

Third party revenue should include patient fees for Medi-Cal share of costs, patient insurance, Medicare, and other revenues received on behalf of Medi-Cal clients in providing Medi-Cal units. This does not include realignment funding. Revenues should be reported on an accrual basis and should be identified as directly as possible to service function or mode level. If revenues cannot be directly identified, use a reasonable method to allocate revenues between inpatient and outpatient services.

Medicare revenues include revenues for services provided during this cost report fiscal year. *Prior year* Medicare revenues *should not* be included in the cost report.

Column M – Units of Service for Enhanced SD/MC (Children)
(July 1, 2006 – September 30, 2006)
Enter the units of service for each service function for Enhanced SD/MC (Children) for the period 07/01/06-09/30/06.

Column N – Units of Service for Enhanced SD/MC (Children)
(October 1, 2006 – June 30, 2007)
Enter the units of service for each service function for Enhanced SD/MC (Children) for the period 10/01/06-06/30/07.

Column O – 3rd Party Revenue Enhanced SD/MC (Children)
Enter 3rd Party Revenue collections for Enhanced SD/MC (Children) services for the entire year. See Columns K & L for more information.

Column P – Units of Service for Enhanced SD/MC (Refugees)
Enter units of service for each service function for Enhanced SD/MC (Refugees) for the entire year. These are units of service that were billed through the SD/MC system using Aid Codes 01, 02, 08, or 0A.

Column Q – 3rd Party Revenue (Refugees)
Enter 3rd Party Revenue collections for refugees for the entire year. See Columns K & L for more information.

Column R – Units of Service – Healthy Families (SED)
(July 1, 2006 – September 30, 2006)
Enter units of service for each service function for Healthy Families for the period of 07/01/06-09/30/06. These are units of service that were billed through the SD/MC system using Aid Codes 7X or 9H.

Column S – Units of Service – Healthy Families (SED)
(October 1, 2006 – June 30, 2007)
Enter units of service for each service function for Healthy Families for the period 10/01/06-06/30/07. These are units of service that were billed through the SD/MC system using Aid Codes 7X or 9H.

Column T – 3rd Party Revenue Healthy Families (SED)
Enter 3rd Party Revenue collections for Healthy Families (SED) for the entire year. See Columns K & L for more information.

Column U – Non-Medi-Cal Units
No entry. This column calculates the total units less all SD/MC units. Column ***U*** equals Column ***D*** less Columns ***G, J, M, N, P, R,*** and ***S.*** If the aggregate of columns ***G, J, M, N, P, R*** and ***S*** is greater than Column ***D,*** you will get an error code in this column. You will need to identify and correct this before continuing.

MH 1901 Schedule C

Supporting Documentation for the Method Used to Allocate Total Cost to Mode of Service and Service Function

MH 1901 Schedule C is designed to automatically pull **direct service costs** for allocation from MH 1960, Line 18. The Settlement Type, Mode, Service Function, and Total Units are automatically populated from MH 1901 Schedule B. This worksheet is also designed to automatically distribute direct service costs to modes and service function through the application of any of the three approved allocation methods. The three allocation methods are: (1) Costs determined at the service function level; (2) Time study; and (3) Relative Value method. The calculations performed here automatically populate MH 1966, Programs 1 and 2. Selection of an "Allocation Method" from the Allocation Box above will allow the distribution of direct service costs to modes and service functions. For example, if you select SMA Rate as an allocation option from the Allocation Box, it means that this worksheet will perform a relative value calculation using information from MH 1901 Schedule A to allocate direct service costs to modes and service functions on MH 1966, Program 1 or 2.

The method chosen must be applied consistently and uniformly to all direct services, and must be consistent from year to year. A legal entity can request to change its allocation method by writing to DMH.

Allocation Methodology

1. **Costs Determined at Service Function Level**
   Some legal entities have the technology and reporting mechanisms to capture costs at the service function level. Legal entities with this capability should allocate costs in this manner.

2. **Time Study**
   The time study procedure used previously to allocate costs between modes of service can be used to allocate costs between service functions. To accomplish this, hours must be reported at the service function level rather than at the mode of service level. The percentage of total is calculated by dividing the costed hours for each service function by the total costed hours.

3. Relative Value

Units of service/time multiplied by the legal entity's charge for each service function determines the relative value assigned to each service function. A legal entity's charge for each service function is: (1) the legal entity's published charge; (2) the legal entity's usual and customary charge; or (3) the legal entity's charge to the general public for providing services. The SMA rate for each service function may be substituted for the legal entity's charge. The relative value for each service function is divided by the sum of all relative values to determine the percentage of the total for each service function. This method should be used by legal entities whose charges are established and updated annually based on the costs of providing the service. The relative value method cannot be used to allocate Mode 05, Service Functions 10 through 19, service costs according to the Department's Fiscal Audits Unit.

State of California Health and Human Services Agency — Department of Mental Health

DETAIL COST REPORT

SUPPORTING DOCUMENTATION FOR THE METHOD USED TO ALLOCATE TOTALS TO MODE OF SERVICE & SERVICE FUNCTION

MH 1901 SCHEDULE C (Rev. 7/06) — FISCAL YEAR 2006 - 2007

Entity Name: 0 — Entity Number: _____

Fiscal Year: 2006 - 2007

Allocation
- ○ Rate for Allocation
- ○ SMA Rate
- ○ Published Charges
- ◉ Directly Allocated

COSTS TO BE ALLOCATED

Allowable Mode Costs (MH1960 Line 18, Col. C)

	A	B	C	D	E	F	G	H	I
						Allocation Basis			
	Settlement Type	Mode	SF	Total Units	Eligible Direct Cost	Directly Allocated Data	Relative Value	Allocation %	Allocated Cost
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									
37									
38									
39									
40									
41									
42									
43									
44									
45									
46									
47									
48									
49									
50									
51									
52									
53									
54									
55									
56									
79									
80									
81									
82									
83									
84									
Totals									

HOME | << MH1960 | MH1969_INST >>

Summary

Mode	Allocated Cost	Allocated %
5 10-19		0.00%
5 Other		0.00%
10		0.00%
15 Program_1		0.00%
45		0.00%
55		0.00%
60		0.00%
Total		0.00%

15 Program_2

Settlement Type	Allocated Cost
TBS	
ASO	
MHS	
Total	

Allocation Method Option Box
Select an Allocation Method

- **Rate for Allocation** – Select "Rate for Allocation" to use the relative value method based on the combined state negotiated rates and county non-Medi-Cal contract rates to allocate costs to modes and service functions. Do not select this option if you have not negotiated all your service functions for a Mode of Service. You can use this allocation method if there are Modes 45 and 60 costs to be allocated.

- **Statewide Maximum Allowances (SMA) Rate** – Select "SMA" for relative value method of cost allocation based on SMAs, if there are SMA rates for all the modes and service functions to be allocated.

- **Published Charges** – Select "Published Charges" for relative value method of cost allocation based on published charges, if you reported published charge rates for all the modes and service functions.

- **Directly Allocated** – Select "Directly Allocated" for the direct cost allocation method. This method can be used if costs were developed based on a time study or any other approved costing method.

Column A – Settlement Type
No entry. This column automatically populates from MH 1901 Schedule B, Column A.

Column B – Mode
No entry. This column automatically populates from MH 1901 Schedule B, Column B.

Column C – Service Function
No entry. This column automatically populates from MH 1901 Schedule B, Column C.

Column D – Total Units
No entry. This column automatically populates from MH 1901 Schedule B, Column D.

Column E – Eligible Direct Cost
Enter costs associated with TBS, ASO, MHS, ISA, MAA and CAW. These costs, except for MAA and CAW, are reported on MH 1966, Program 2, based on actual costs to the county. Non-Medi-Cal costs for Modes 45 and 60 may also be entered in this column.

Column F – Directly Allocated Cost
Enter amount for direct allocation to each service function on MH 1966, Program 1. In order to use this column for direct allocation, you must select "Directly Allocated" option from the allocation method selection box. Do not report amounts associated with TBS, MAA, ASO, ISA, MHS and CAW in this column.

Column G – Relative Value
No entry. This column computes the relative value using the selected allocation base. Relative value is the product of multiplying negotiated rate, SMA or published charges by the service function total units of service. For example, if Published Charges is the selected allocation base from the "Allocation Method" option box, the amount generated and placed in Column G will be the product of the published charge rate from MH 1901 Schedule A published charge column, and the total units reported on MH 1901 Schedule C, Column D for each service function.

Column H – Allocation Percentage
No entry. This column computes the allocation percentages for each service function. This is achieved by dividing each service function relative value statistics by the aggregate of all the service functions relative value statistics.

Column I – Allocated Cost
No entry. This column computes the allocated cost for each service function. Allocated cost is the product of Column H and MH 1960, Column C, Line 18 minus Column E total. Total direct service costs for allocation includes Eligible Direct Cost from Column E.

NOTE: If data is entered on Column E – Eligible Direct Cost and Column F – Directly Allocated Costs, the sum of Columns E and F **SHOULD** equal the amount shown on Column I. If they do not, the county is responsible for maintaining supporting documentation as to their allocation methodology.

MH 1960

Calculation of Program Costs

The purpose of MH 1960 is to adjust legal entity costs for Medi-Cal principles of reimbursement, identify the adjusted costs applicable to administration, utilization review, research and evaluation, Medi-Cal Administrative Activities (MAA), and direct service modes of service or cost centers.

Line 1 – Mental Health Expenditure
County legal entities should report total gross expenditures for county mental health department or division from the county auditor-controller's report. Amount should include all inter/intra fund transfers and contra entries should be reported as gross expenditures prior to applying revenues. Expenditures should include Healthy Families and Enhanced Medi-Cal funds. The amount on Line 1, Column C should match the total on the summary page of the auditor-controller's report, or the county should maintain work papers that reconcile the amount reported on Line 1, Column C to the auditor-controller's report. Contract provider legal entities should report total gross expenditures from their trial balance.

Column A – Enter the mental health Salaries and Benefits expenditures.
Column B – Enter all Other mental health expenditures.
Column C – No entry. This column sums Columns A and B.

Line 2 – Encumbrances
Add encumbrances incurred by the legal entity during the cost report fiscal year not reported on Line 1, and subtract encumbrances included in Line 1 not applicable to the cost report fiscal year.

Column A – Enter the Salaries and Benefits encumbrances for the fiscal year.
Column B – Enter the Other encumbrances for the fiscal year.
Column C – No entry. This column automatically populates from Columns A and B.

Line 3 – Less: Payments to Contract Providers (County Only) from MH 1963

No entry. Information for this line automatically populates from MH 1963, Column D, Total Payments to Contract Providers.

Column A – No entry.

Column B – No entry. This column automatically populates from MH 1963, Column D, Total Payments for Contract Providers.

Column C – No entry. This column automatically populates from Column B.

State of California Health and Human Services Agency — Department of Mental Health

DETAIL COST REPORT

CALCULATION OF PROGRAM COSTS

MH 1960 (Rev. 7/06) — FISCAL YEAR 2006 - 2007

County: 0
County Code:

	Legal Entity:	A	B	C
	Legal Entity Number:	Salaries and Benefits	Other	Total Costs
1	Mental Health Expenditures			
2	Encumbrances			
3	Less: Payments to Contract Providers (County Only)			
4	Other Adjustments from MH 1962			
5	Total Costs Before Medi-Cal Adjustments			
6	Medi-Cal Adjustments from MH 1961			
7	Managed Care Consolidation (County Only)			
8	Allowable Costs for Allocation			
	Administrative Costs (County Only)			
9	SD/MC Administration			
10	Healthy Families Administration			
11	Non-SD/MC Administration			
12	Total Administrative Costs			
	Utilization Review Costs (County Only)			
13	Skilled Professional Medical Personnel			
14	Other SD/MC Utilization Review			
15	Non-SD/MC Utilization Review			
16	Total Utilization Review Costs			
17	Research and Evaluation (County Only)			
18	Mode Costs (Direct Service and MAA)			
19	Total Costs - Lines 9 through 18			

Crosscheck
0 OK
0 OK

HOME | MH1901_Schedule_C >> | << MH1961 | << MH1962 | << MH1963

Line 4 – Other Adjustments

No entry. Information for this line automatically populates from MH 1962, Columns A, B, and C, Line 20.

Column A – No entry. Salary and Benefits automatically populates from MH 1962, Column A, Line 20.

Column B – No entry. Adjustments to cost other than Salary and Benefits automatically populates from MH 1962, Column B, Line 20.

Column C – No entry. Automatically populates from the sum of Columns A and B.

Line 5 – Total Costs Before Medi-Cal Adjustments
Columns A, B and C – No entry. This line is the sum of Lines 1 through 4.

Line 6 – Medi-Cal Adjustments
No entry. The total Medi-Cal Adjustment is automatically populated from MH 1961, Line 20, Column C. Refer to Center for Medicare and Medicaid Services (CMS) Publication 15, Provider Reimbursement Manual Parts I & II for further explanation of Medi-Cal allowable and non-allowable costs.

NOTE: Treatment of depreciation under Medi-Cal is different than under "realignment" without Medi-Cal. Medi-Cal adjustments can be either additions or subtractions to total cost, depending on the types of adjustments. For example, most counties expense equipment as purchased. Medi-Cal principles dictate that the purchase of equipment should be depreciated over the life of the asset, thereby reducing the allowable costs in the year of acquisition, and increasing allowable costs in subsequent years.

Line 7 – Managed Care Consolidation. (Community Services Managed Care-Outpatient Mental Health Services) – <u>County Only</u>
County legal entities are to enter the "Outpatient Mental Health Services" expenditures funded through Community Services – Managed Care allocation (Line 8 of MH 1994) if not included in Line 1. Rollover of FY 2005-2006 managed care funds expended for Outpatient Mental Health Services (Line 2b of MH 1994) should also be included here, if not included in Line 1.

Column C – Enter the expenditures funded through Community Services and the rollover FY 2005-2006 managed care funds expended for Outpatient Mental Health Services if they were not included in Line 1.

Line 8 – Allowable Costs for Allocation
Column C – No entry. This line is the sum of Lines 5, 6 and 7.

The allowable costs on Line 8 are to be allocated among administrative cost centers, utilization review cost centers, research and evaluation, direct services and MAA.

Lines 9 through 12 – Administrative Cost – <u>County Only</u>
County legal entities should report administrative costs on Lines 9, 10 and 11 in Column C. These costs are summed on Line 12 (no entry required on Line 12). Administrative costs should be apportioned between Line 9 (SD/MC including Inpatient FFS/MC), Line 10 (Healthy Families), and Line 11 (non-SD/MC) using: (1) the percentage of Medi-Cal recipients in the population served by the county; (2) relative values based on units and published charges; or (3) gross costs of each program. Follow the instructions in the *<u>Medi-Cal Administrative Activities (MAA) Instruction Manual</u>* for guidance on how to determine the percentage of Medi-Cal recipients. Refer to instructions for MH 1901 Schedule C if relative value is the method chosen.

Lines 13 through 16 – Utilization Review Costs – County Only
County legal entities should report Utilization Review costs on Lines 13 through 16 in Column C. Skilled Professional Medical Personnel cost should be reported on Line 13, Other SD/MC Utilization Review (Line 14), and Non-SD/MC Utilization Review (Line 15). Amount reported on Line 13 is reimbursed at the enhanced rate (75 percent FFP). Documentation supporting the amount on Line 13 must be maintained by the county legal entity. *MAA Instruction Manual* provides a detailed discussion of how to identify Skilled Professional Medical Personnel.

If the county performs utilization review of all services regardless of client Medi-Cal eligibility, a portion of the utilization review cost should be reported on Line 15. These costs are summed on Line 16 (no entry required on Line 16).

Line 17 – Research and Evaluation
County legal entities should enter research and evaluation costs on Line 17. Research includes costs for centralized activities under the direction of the Local Mental Health Director designed to increase the scientific knowledge and understanding of the nature, cause, prevention, and treatment of mental, emotional, or behavioral disorders. Evaluation includes the cost of scientific studies regarding the effectiveness and efficiency of specific mental health programs in which goals are clearly defined and achieved in measurable terms. Line 17 should not include Medi-Cal reimbursable costs. Costs of studies, analyses, surveys, and related activities aimed at improving and making provider administration and operation more efficient are not considered research costs and should not be reported on Line 17.

Line 18 – Mode Costs (Direct Service and MAA) – County Only
All legal entities must enter the direct service and MAA costs on Line 18, Column C. This includes all direct costs of providing mental health services and all MAA costs.

Line 19 – Total Costs – Lines 9 through 18
No entry. Line 19 is the sum of Lines 12, 16, 17 and 18. The total amount on Line 19 should equal the amount on Line 8. Any difference between the two amounts should be corrected before proceeding.

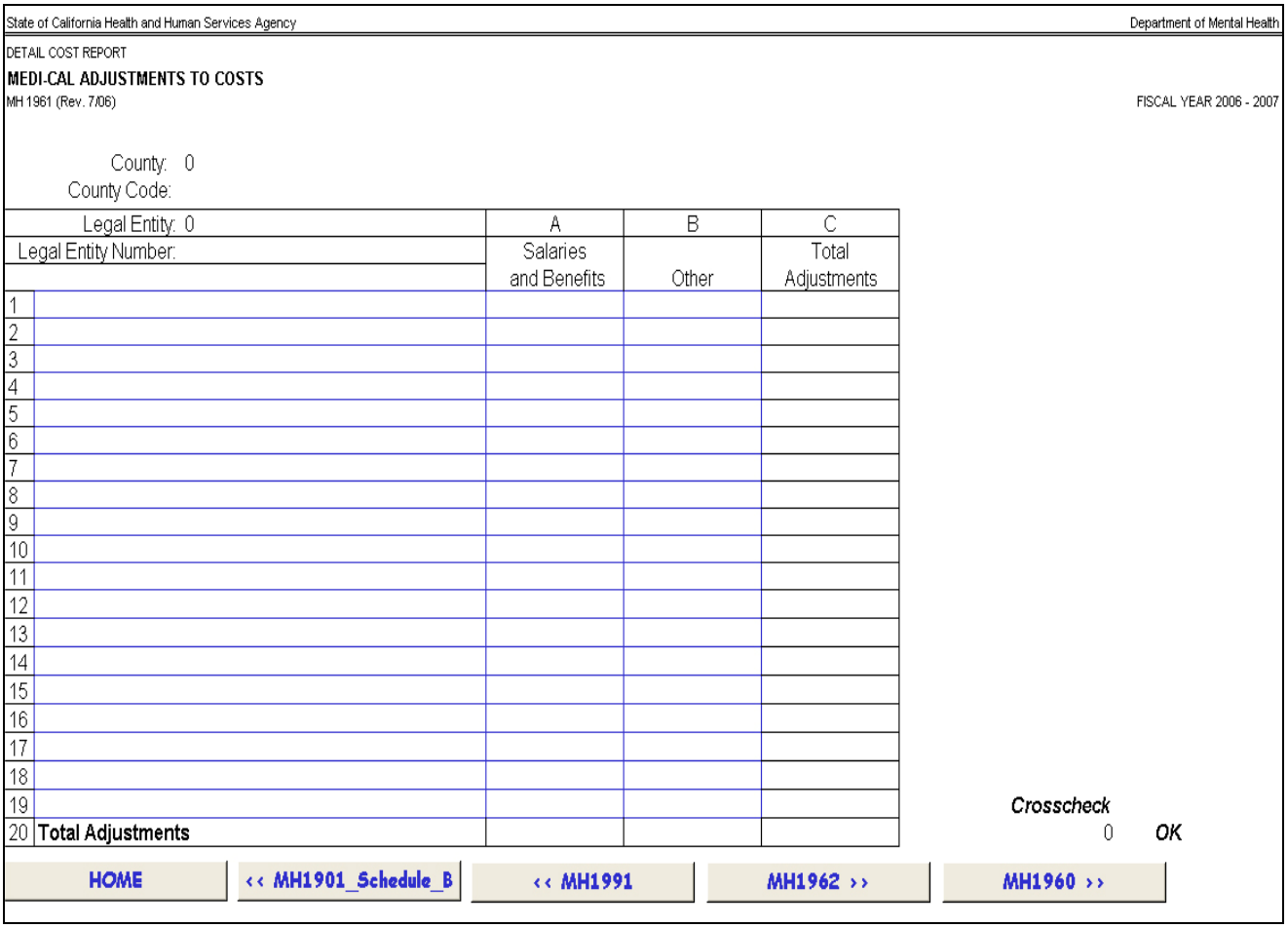
MH 1961

Medi-Cal Adjustments to Costs

The purpose of MH 1961 is to calculate adjustments to costs for Medi-Cal and Medicare principles of allowable costs. Adjustments identified on this form are transferred to MH 1960, Line 6. Refer to Center for Medicare and Medicaid Services (CMS) Publication 15, Provider Reimbursement Manual Parts I & II for further explanation of Medi-Cal allowable and non-allowable costs.

Lines 1 through 19
Enter all applicable adjustments to costs for Medi-Cal and Medicare principles of allowable costs. Column C automatically populates the sum of Columns A and B.

Line 20 – Total Adjustments
No entry. Sum of Lines 1 through 19 for each column. The amount in Column C will be entered on MH 1960, Line 6, Column C.



State of California Health and Human Services Agency — Department of Mental Health

DETAIL COST REPORT

MEDI-CAL ADJUSTMENTS TO COSTS

MH 1961 (Rev. 7/06) — FISCAL YEAR 2006 - 2007

County: 0
County Code:

Legal Entity: 0 Legal Entity Number:		A Salaries and Benefits	B Other	C Total Adjustments
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20	Total Adjustments			

Crosscheck 0 OK

HOME | << MH1901_Schedule_B | << MH1991 | MH1962 >> | MH1960 >>

MH 1962

Other Adjustments

The purpose of MH 1962 is to provide detail information of other adjustments for each activity. Information entered here will automatically populate MH 1960, Line 4, Columns A, B and C.

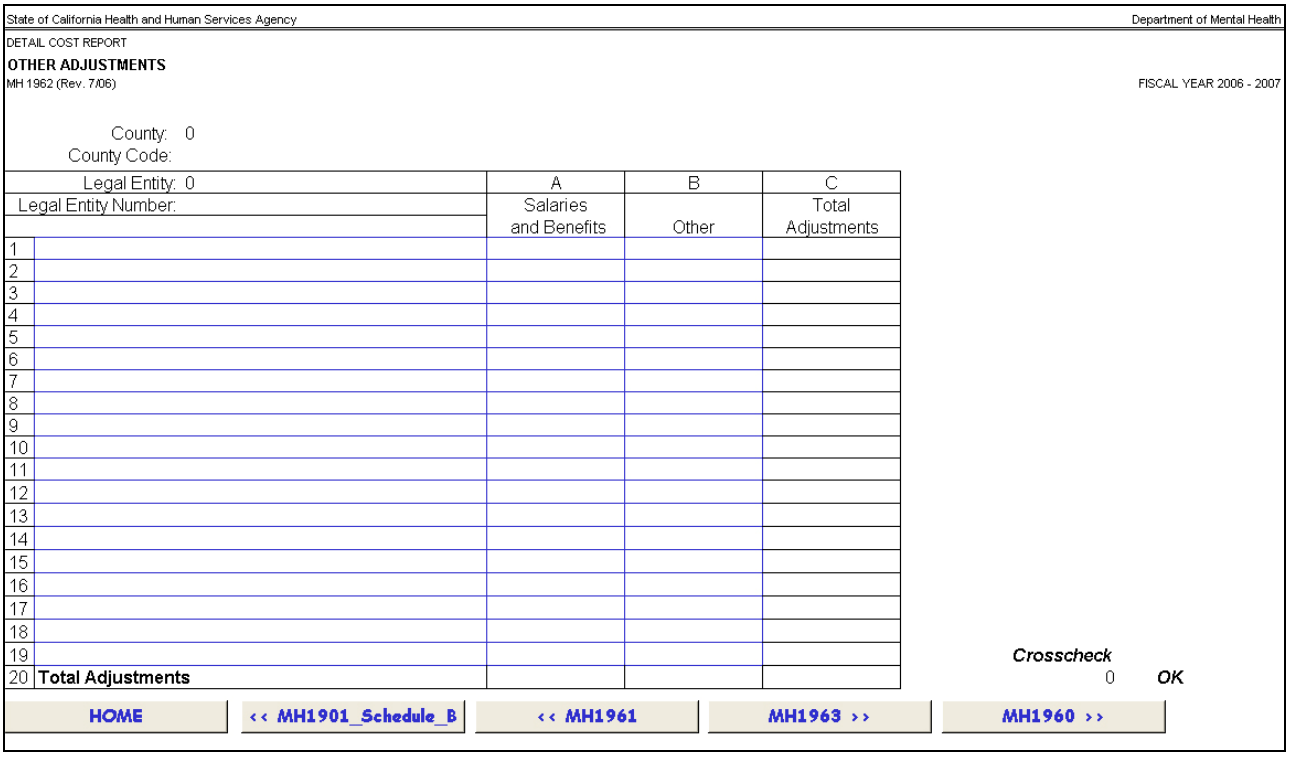
Add or subtract any other adjustments to costs the legal entity might have on this form. For example, if the amount reported on MH 1960, Line 1 from the county auditor-controller's report includes the costs of the county substance abuse division, the costs of the substance abuse division would be deducted on MH 1960, Line 4. Also, if the COWCAP A-87 (county overhead) costs were not included in the county auditor-controller's report, these costs would be added on MH 1960, Line 4. Audit adjustments also should be included on MH 1960, Line 4. Other situations that are unique for individual legal entities should be addressed on MH 1960, Line 4.

Lines 1 through 19

Enter all other adjustments to costs on Columns A and B for Lines 1 through 19. Column C automatically populates the sum of Columns A and B.

Line 20 – Total Adjustments

No entry. Sum of Lines 1 through 19 for each column. The amount in Column C will automatically populate MH 1960, Line 4, Column C.



State of California Health and Human Services Agency — Department of Mental Health

DETAIL COST REPORT

OTHER ADJUSTMENTS

MH 1962 (Rev. 7/06) — FISCAL YEAR 2006 - 2007

County: 0
County Code:

Legal Entity: 0		A	B	C
Legal Entity Number:		Salaries and Benefits	Other	Total Adjustments
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20	**Total Adjustments**			

Crosscheck 0 *OK*

HOME | << MH1901_Schedule_B | << MH1961 | MH1963 >> | MH1960 >>

MH 1963

Payments to Contract Providers (County Only)

The purpose of MH 1963 is to capture the payments to contract providers. Information entered here will automatically populate MH 1960, Line 3, Columns B and C.

Payments to contract provider legal entities include all interim payments to providers with which the county has a service contract and should be reported in the year in which services/units are provided. This does not include payments to hospitals operated by other county departments. Payments for fee-for-service vendor contracts should not be included on this line. Most county legal entities will not record the Fee-for-Service/Medi-Cal (FFS/MC) payments in their auditor-controller's report because these payments are pass-through funds to the hospital. These payments would not be included on MH 1960, Line 1 or Line 3. **If payments to FFS/MC** hospitals contracted under inpatient consolidation **are included on MH 1960, Line 1,** these expenditures should be included on this line in order to reduce total mental health expenditures by the FFS/MC amount. Payments to contract providers should be reported in the year in which services/units are provided.

Column B – Enter the contract provider's legal entity name or one entry for the FFS/MC hospitals.
Column C – Enter the contract provider's legal entity number.
Column D – Enter the amount paid to the contract provider. This amount should equal at least the amount on the legal entity cost report. A cost report should be submitted for each contract provider payment listed.

State of California Health and Human Services Agency — Department of Mental Health

DETAIL COST REPORT
PAYMENTS TO CONTRACT PROVIDERS
MH 1963 (Rev. 7/06) — FISCAL YEAR 2006 - 2007

County: 0
County Code:

A	B	C	D
Item	Legal Entity Name	Legal Entity Number	Amount Paid
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49			
50			
	Total Payments to Contract Providers		

HOME | MH1960 >> | Add Line Items

MH 1964

Allocation of Costs to Modes of Service

The purpose of MH 1964 is to distribute mode costs to various modes of service, including MAA. ***See Appendix E for mode of service information.***

Line 1 – Mode Costs (Direct Service and MAA) from MH 1960
No entry. Automatically populates the direct service costs from Line 18 of MH 1960.

Lines 2 through 8 – Modes
No entry. The costs for each mode of service are automatically populated from MH 1901 Schedule C, Column I.

Line 9 – Total – Lines 2 through 8
No entry. This line sums Lines 2 through 8. The amount on Line 9 should equal the amount on Line 1. Any difference between the two amounts should be corrected on MH 1960, Lines 9 through 18 before proceeding.

State of California Health and Human Services Agency — Department of Mental Health

DETAIL COST REPORT

ALLOCATION OF COSTS TO MODES OF SERVICE

MH 1964 (Rev. 7/06) — FISCAL YEAR 2006 - 2007

County: 0
County Code:

	Legal Entity: 0	A
	Legal Entity Number:	Total Costs
1	Mode Costs (Direct Service and MAA) from MH 1960	
	Modes	
2	Hospital Inpatient Services (Mode 05-SFC 10-19)	
3	Other 24 Hour Services (Mode 05-All Other SFC)	
4	Day Services (Mode 10)	
5	Outpatient Services (Mode 15 Program 1 + Program 2)	
6	Outreach Services (Mode 45)	
7	Medi-Cal Administrative Activities (Mode 55)	
8	Support Services (Mode 60)	
9	Total - Lines 2 through 8	

Crosscheck OK

HOME

MH 1966 Program 1 and Program 2

Allocation of Costs to Service Functions – Mode Total

MH 1966, Program 1 and Program 2 distribute modes of service costs to the service function level. Program 2 accounts for pass-through costs incurred by fee-for-service contract providers, TBS-only contract providers, non-organizational MHS providers, ASO etc. ***Service functions are listed in the CFRS system format chart (Appendix E).*** These forms also determine aggregate SD/MC, Medicare/Medi-Cal Crossover Costs, Enhanced SD/MC Costs, Healthy Families Costs, Published Charges, SMA for SD/MC, and Negotiated Rate amounts for each mode of service. MH 1966 forms for Modes 45 and 60 are simplified from the other MH 1966 forms and determine non-Medi-Cal costs for each mode of service. MH 1966 for Mode 55 is also simplified from other MH 1966 forms and identifies the MAA costs for those participating in the MAA program.

MH 1966 automatically populates from MH 1901 Schedules A, B and C. Separate MH 1966 forms are automatically populated for each mode of service.

Line 1 – Allocation Percentage
No Entry. The allocation percentage is determined by taking the Total Allocated Cost for each service function from MH 1901 Schedule C divided by the Total Allocated Cost for the respective mode of the above service functions.

Line 2 – Total Units
No entry. This field is automatically populated from MH 1901 Schedule C, Column D.

Line 3 – Gross Cost
No entry. This field is automatically populated from MH 1901 Schedule C, Column I. The distribution of the amount on Line 3, Column A, to the appropriate service functions fills in automatically from MH 1901 Schedule C, starting in Column B.

Line 4 – Cost per Unit
No entry. Starting in Column B, Line 3 is automatically divided by Line 2 for each service function level.

Line 5 – SMA per Unit
No entry. Starting in Column B, this field is automatically populated from MH 1901 Schedule A, Column C.

State of California Health and Human Services Agency — Department of Mental Health

DETAIL COST REPORT

ALLOCATION OF COSTS TO SERVICE FUNCTIONS - MODE TOTAL

PAGE 1 OF 1

MH 1966 (Rev. 7/06) FISCAL YEAR 2006 - 2007

County: 0
County Code:
Legal Entity: 0
Legal Entity Number:
Mode: 15 - Outpatient Services (Program 1)

			A	B	C	D	E	F	G
			Mode Total	Service Function	Service Function	Service Function	Service Function	Service Function	Service Function
1	Allocation Percentage								
2	Total Units								
3	Gross Cost								
4	Cost per Unit								
5	SMA per Unit								
6	Published Charge per Unit								
7	Negotiated Rate / Cost per Unit								
8	Medi-Cal Units	07/01/06 - 09/30/06							
8A		10/01/06 - 06/30/07							
9	Medicare/Medi-Cal Crossover Units	07/01/06 - 09/30/06							
9A		10/01/06 - 06/30/07							
10	Enhanced SD/MC (Children) Units	07/01/06 - 09/30/06							
10A		10/01/06 - 06/30/07							
10B	Enhanced SD/MC (Refugees) Units	07/01/06 - 06/30/07							
11	Healthy Families (SED) Units	07/01/06 - 09/30/06							
11A		10/01/06 - 06/30/07							
12	Non-Medi-Cal Units								
13	Medi-Cal Costs	07/01/06 - 09/30/06							
13A		10/01/06 - 06/30/07							
14	Medi-Cal SMA Upper Limits	07/01/06 - 09/30/06							
14A		10/01/06 - 06/30/07							
15	Medi-Cal Published Charges	07/01/06 - 09/30/06							
15A		10/01/06 - 06/30/07							
16	Medi-Cal Negotiated Rates	07/01/06 - 09/30/06							
16A		10/01/06 - 06/30/07							
17	Medicare/Medi-Cal Crossover Costs	07/01/06 - 09/30/06							
17A		10/01/06 - 06/30/07							
18	Medicare/Medi-Cal Crossover SMA Upper Limits	07/01/06 - 09/30/06							
18A		10/01/06 - 06/30/07							
19	Medicare/Medi-Cal Crossover Published Charges	07/01/06 - 09/30/06							
19A		10/01/06 - 06/30/07							
20	Medicare/Medi-Cal Crossover Negotiated Rates	07/01/06 - 09/30/06							
20A		10/01/06 - 06/30/07							
21	Enhanced SD/MC Costs	07/01/06 - 09/30/06							
21A		10/01/06 - 06/30/07							
22	Enhanced SD/MC SMA Upper Limits	07/01/06 - 09/30/06							
22A		10/01/06 - 06/30/07							
23	Enhanced SD/MC Published Charges	07/01/06 - 09/30/06							
23A		10/01/06 - 06/30/07							
24	Enhanced SD/MC Negotiated Rates	07/01/06 - 09/30/06							
24A		10/01/06 - 06/30/07							
25	Enhanced SD/MC (Refugees) Costs	07/01/06 - 06/30/07							
26	Enhanced SD/MC (Refugees) SMA Upper Limits	07/01/06 - 06/30/07							
27	Enhanced SD/MC (Refugees) Published Charges	07/01/06 - 06/30/07							
28	Enhanced SD/MC (Refugees) Negotiated Rates	07/01/06 - 06/30/07							
29	Healthy Families Costs	07/01/06 - 09/30/06							
29A		10/01/06 - 06/30/07							
30	Healthy Families SMA Upper Limits	07/01/06 - 09/30/06							
30A		10/01/06 - 06/30/07							
31	Healthy Families Published Charges	07/01/06 - 09/30/06							
31A		10/01/06 - 06/30/07							
32	Healthy Families Negotiated Rates	07/01/06 - 09/30/06							
32A		10/01/06 - 06/30/07							
33	Non-Medi-Cal Costs								

Line 6 – Published Charge per Unit

No entry. Starting in Column B, this field automatically populates from MH 1901 Schedule A, Column E. See MH 1901 Schedule A instruction for more information.

Line 7 – Negotiated Rate/Cost per Unit

No entry. If applicable, the rate negotiated between the local mental health agency, the legal entity and approved by the State (DMH) for each SD/MC service function fills in automatically from MH 1901 Schedule A, Column D. If the legal entity has a mixture of service function categories with and without negotiated rates, this line will fill in with either the NR or the Cost per unit. This is to prevent the data from becoming skewed when these amounts are aggregated on MH 1968.

Line 8 – Medi-Cal Units
(July 1, 2006 – September 30, 2006)
No entry. Starting in Column B, Medi-Cal units (from billing records) for each Medi-Cal service function fills in automatically from MH 1901 Schedule B, Column E. This field identifies only units for the first quarter of the fiscal year. Do not include Medicare/Medi-Cal crossover or enhanced SD/MC units.

Line 8A – Medi-Cal Units
(October 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Medi-Cal units (from billing records) for each Medi-Cal service function fills in automatically from MH 1901 Schedule B, Column F. This field identifies only units for the second, third, and fourth quarters of the fiscal year. Do not include Medicare/Medi-Cal Crossover or Enhanced SD/MC units.

Line 9 – Medicare/Medi-Cal Crossover Units
(July 1, 2006 – September 30, 2006)
No entry. Starting in Column B, Medicare/Medi-Cal Crossover units for each Medi-Cal service function fills in automatically from MH 1901 Schedule B, Column H. This field identifies only units for the first quarter of the fiscal year.

Line 9A – Medicare/Medical Crossover Units
(October 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Medicare/Medi-Cal crossover units for each Medi-Cal service function fills in automatically from MH 1901 Schedule B, Column I. This field identifies only units for the second, third and fourth quarters of the fiscal year.

Line 10 – Enhanced SD/MC (Children) Units
(July 1, 2006 – September 30, 2006)
No entry. Starting in Column B, Enhanced SD/MC (Children) units for each Medi-Cal service function fills in automatically from MH 1901 Schedule B, Column M for the first quarter of the fiscal year.

Line 10A – Enhanced SD/MC (Children) Units
(October 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Enhanced SD/MC (Children) units for each Medi-Cal service function fills in automatically from MH 1901 Schedule B, Column N for the second, third and fourth quarters of the fiscal year.

Line 10B – Enhanced SD/MC (Refugees) Units
(July 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Enhanced SD/MC (Refugees) units for each Medi-Cal service function fills in automatically from MH 1901 Schedule B, Column P.

Line 11 – Healthy Families (SED) Units
(July 1, 2006 – September 30, 2006)
No entry. Starting in Column B, Healthy Families units for each Healthy Families service function fills in automatically from MH 1901 Schedule B, Column R for the first quarter of the fiscal year.

Line 11A – Healthy Families (SED) Units
(October 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Healthy Families units for each Healthy Families service function fills in automatically from MH 1901 Schedule B, Column S for the second, third and fourth quarters of the fiscal year.

Line 12 – Non-Medi-Cal Units
No entry. Starting in Column B, non-Medi-Cal units for each service function fills in automatically from MH 1901 Schedule B, Column U.

Line 13 – Medi-Cal Costs
(July 1, 2006 – September 30, 2006)
No entry. Starting in Column B, Line 4 is multiplied by Line 8 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 13.

Line 13A – Medi-Cal Costs
(October 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Line 4 is multiplied by Line 8A for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 13A.

Line 14 – Medi-Cal SMA Upper Limits
(July 1, 2006 – September 30, 2006)
No entry. Starting in Column B, Line 5 is multiplied by Line 8 for each SD/MC service function. The products of all SD/MC service functions computed are summed up automatically in Column A, Line 14.

Line 14A – Medi-Cal SMA Upper Limits
(October 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Line 5 is multiplied by Line 8A for each SD/MC service function. The products of all SD/MC service functions computed are summed up automatically in Column A, Line 14A.

Line 15 – Medi-Cal Published Charges
(July 1, 2006 – September 30, 2006)
No entry. Starting in Column B, Line 6 is multiplied by Line 8 for each SD/MC service function. The products of total published charges computed for all service functions are summed up automatically on Column A, Line 15.

Line 15A – Medi-Cal Published Charges
(October 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Line 6 is multiplied by Line 8A for each SD/MC service function. The products of total published charges computed for all service functions are summed up automatically on Column A, Line 15A.

Line 16 – Medi-Cal Negotiated Rates
(July 1, 2006 – September 30, 2006)
No entry. If applicable, starting in Column B, Line 7 is multiplied by Line 8 for each SD/MC service function. The products of all SD/MC service functions computed are summed up automatically in Column A, Line 16.

Line 16A – Medi-Cal Negotiated Rates
(October 1, 2006 – June 30, 2007)
No entry. If applicable, starting in Column B, Line 7 is multiplied by Line 8A for each SD/MC service function. The products of all SD/MC service functions computed are summed up automatically in Column A, Line 16A.

Line 17 – Medicare/Medi-Cal Crossover Costs
(July 1, 2006 – September 30, 2006)
No entry. If applicable, starting in Column B, Line 4 is multiplied by Line 9 for each SD/MC service function. The products of all SD/MC service functions computed are summed up automatically in Column A, Line 17.

Line 17A – Medicare/Medi-Cal Crossover Costs
(October 1, 2006 – June 30, 2007)
No entry. If applicable, starting in Column B, Line 4 is multiplied by Line 9A for each SD/MC service function. The products of all SD/MC service functions computed are summed up automatically in Column A, Line 17A.

Line 18 – Medicare/Medi-Cal Crossover SMA Upper Limits
(July 1, 2006 – September 30, 2006)
No entry. Starting in Column B, Line 5 is multiplied by Line 9 for each SD/MC service function. The products of all SD/MC service functions computed are summed up automatically in Column A, Line 18.

Line 18A – Medicare/Medi-Cal Crossover SMA Upper Limits
(October 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Line 5 is multiplied by Line 9A for each SD/MC service function. The products of all SD/MC service functions computed are summed up automatically in Column A, Line 18A.

Line 19 – Medicare/Medi-Cal Crossover Published Charges
(July 1, 2006 – September 30, 2006)
No entry. If applicable, starting in Column B, Line 6 is multiplied by Line 9 for each SD/MC service function. The products of total published charges for all service functions computed are summed up in Column A, Line 19.

Line 19A – Medicare/Medi-Cal Crossover Published Charges
(October 1, 2006 – June 30, 2007)
No entry. If applicable, starting in Column B, Line 6 is multiplied by Line 9A for each SD/MC service function. The products of total published charges for all service functions computed are summed up in Column A, Line 19A.

Line 20 – Medicare/Medi-Cal Crossover Negotiated Rates
(July 1, 2006 – September 30, 2006)
No entry. If applicable, starting in Column B, Line 7 is multiplied by Line 9 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 20.

Line 20A – Medicare/Medi-Cal Crossover Negotiated Rates
(October 1, 2006 – June 30, 2007)
No entry. If applicable, starting in Column B, Line 7 is multiplied by Line 9A for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 20A.

Line 21 – Enhanced SD/MC (Children) Costs
(July 1, 2006 – September 30, 2006)
No entry. Starting in Column B, Line 4 is multiplied by Line 10 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 21.

Line 21A – Enhanced SD/MC (Children) Costs
(October 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Line 4 is multiplied by Line 10A for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 21A.

Line 22 – Enhanced SD/MC (Children) SMA Upper Limits
(July 1, 2006 – September 30, 2006)
No entry. Starting in Column B, Line 5 is multiplied by Line 10 by each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 22.

Line 22A – Enhanced SD/MC (Children) SMA Upper Limits
(October 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Line 5 is multiplied by Line 10A for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 22A.

Line 23 – Enhanced SD/MC (Children) Published Charges
(July 1, 2006 – September 30, 2006)
No entry. Starting in Column B, Line 6 is multiplied by Line 10 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 23.

Line 23A – Enhanced SD/MC (Children) Published Charges
(October 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Line 6 is multiplied by Line 10A for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 23A.

Line 24 – Enhanced SD/MC (Children) Negotiated Rates
(July 1, 2006 – September 30, 2006)
No entry. Starting in Column B, Line 7 is multiplied by Line 10 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 24.

Line 24A – Enhanced SD/MC (Children) Negotiated Rates
(October 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Line 7 is multiplied by Line 10A for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 24A.

Line 25 – Enhanced SD/MC (Refugees) Costs
(July 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Line 4 is multiplied by Line 10B for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 25.

Line 26 – Enhanced SD/MC (Refugees) SMA Upper Limits
(July 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Line 5 is multiplied by Line 10B for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 26.

Line 27 – Enhanced SD/MC (Refugees) Published Charges
(July 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Line 6 is multiplied by Line 10B for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 27.

Line 28 – Enhanced SD/MC (Refugees) Negotiated Rates
(July 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Line 7 is multiplied by Line 10B for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 28.

Line 29 – Healthy Families Costs
(July 1, 2006 – September 30, 2006)
No entry. Starting in Column B, Line 4 is multiplied by Line 11 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 29.

Line 29A – Healthy Families Costs
(October 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Line 4 is multiplied by Line 11A for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 29A.

Line 30 – Healthy Families SMA Upper Limits
(July 1, 2006 – September 30, 2006)
No entry. Starting in Column B, Line 5 is multiplied by Line 11 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 30.

Line 30A – Healthy Families SMA Upper Limits
(October 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Line 5 is multiplied by Line 11A for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 30A.

Line 31 – Healthy Families Published Charges
(July 1, 2006 – September 30, 2006)
No entry. Starting in Column B, Line 6 is multiplied by Line 11 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 31.

Line 31A – Healthy Families Published Charges
(October 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Line 6 is multiplied by Line 11A for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 31A.

Line 32 – Healthy Families Negotiated Rates
(July 1, 2006 – September 30, 2006)
No entry. Starting in Column B, Line 7 is multiplied by Line 11 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 32.

Line 32A – Healthy Families Negotiated Rates
(October 1, 2006 – June 30, 2007)
No entry. Starting in Column B, Line 7 is multiplied by Line 11A for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 32A.

Line 33 – Non-Medi-Cal Costs
No entry. Starting in Column B, Line 3 minus the sum of Lines 13, 13A, 17, 17A, 21, 21A, 25, 29, and 29A is entered here. The amounts for all service functions are summed up in Column A, Line 33.

MH 1966 Mode 05, Service Function 19

Hospital Inpatient

The SMA rate for this service function does not include Physician and Ancillary service costs. The intent of this procedure is to ensure that Physician and Ancillary costs related to these Hospital Administrative Days are included in the comparison of the costs, SMA, published charges, and negotiated rates (if applicable). Legal entities with hospital administrative days should complete MH 1991 for the purpose of grossing up the SMA to include Physician and Ancillary costs.

NOTE: You will need to complete the MH 1991 even if you do not have any Physician and Ancillary costs. The SMA costs are pulled directly from the MH 1991.

Upon Completion of Form MH 1991, MH 1966 for Mode 05, Service Function 19 fills in automatically from MH 1901 Schedules A, B and C, and MH 1991:

Lines 1 through 5
No entry. These fields fill in automatically from MH 1901 Schedules B and C.

NOTE: Line 3 should include Physician and Ancillary costs related to patients on administrative day status (costs are limited to those claimable under Section 51511(c), Title 22 of the California Code of Regulations (CCR).

Lines 6, 8, 8A, 13, and 13A
No entry. Lines 6, 8, and 8A fill in automatically from MH 1901 Schedule B. Lines 13 and 13A automatically compute.

Line 7 – Negotiated Rate/Cost per unit
No entry. Mode 05, Service Function 19 has no negotiated rate. If the legal entity has a mixture of service function categories with and without negotiated rates, this line will fill in with either the negotiated rate or the cost per unit. This is done so that when these amounts are aggregated on MH 1968, the data are not skewed.

Lines 9, 9A and 17, 17A through 20, 20A
These lines do not apply to this service function and should be left blank. Administrative Days cannot have crossover units because Medicare will not pay for those beds.

Line 12 – Non-Medi-Cal Units
No entry. This field automatically populates from MH 1901 Schedule B.

Line 13/13A – Medi-Cal Costs
No entry. This field computes Line 4 multiplied by Line 8 (Line 8A).

Line 14/14A – Medi-Cal SMA Upper Limits
No entry. These fields include Physician and Ancillary costs. It computes automatically by referencing MH 1991, Column I (Physician costs + Ancillary costs).

Line 15/15A – Medi-Cal Published Charges
No entry. These fields automatically compute. The fields are the products of multiplying Line 6 by Line 8 (Line 8A). The published charge should include Physician and Ancillary costs.

Line 16/16A – Medi-Cal Negotiated Rates
No entry. Mode 05, Service Function 19 cannot have a negotiated rate, but if the Legal Entity has a mixture of service function categories with and without negotiated rates, this line will fill in the lower of Costs, SMA with Physician and Ancillary Costs or Charges. This is done so that when these amounts are aggregated on the MH 1968, the data are not skewed.

Line 22/22A – Enhanced SD/MC (Children) SMA Upper Limits
No entry. Line 5 is multiplied by Line 10/10A for each Mode 05, Service Function 19 entry. In addition, the Physician and Ancillary costs identified in MH 1991 for the specific time period and settlement group (Children EMC) are added to amounts that are automatically entered here.

Line 26 – Enhanced SD/MC (Refugees) SMA Upper Limits
No entry. Line 5 is multiplied by Line 10B for each Mode 05, Service Function 19 entry. In addition, the Physician and Ancillary costs identified in MH 1991 for the specific time period and settlement group (Refugees EMC) are added to amounts that are automatically entered here.

Line 30/30A – Healthy Families (SED) SMA Upper Limits
No entry. Line 5 is multiplied by Line 11/11A for each Mode 05, Service Function 19 entry. In addition, Physician and Ancillary costs identified in MH 1991 for the specific time period and settlement group (Healthy Families) are added to amounts that are automatically entered here.

Line 33 – Non-Medi-Cal Costs
No entry. Line 3 minus the sum of Lines 13, 13A, 21, 21A, 25, 29, and 29A is automatically entered here.

MH 1966 Modes 45 and 60

Outreach and Support

MH 1966 for Mode 45 (Outreach) and Mode 60 (Support) services, are non-Medi-Cal reimbursable. For these modes, the format consists of only six lines. MH 1966 for Modes 45 and 60, automatically populates from MH 1901 Schedules A, B and C.

Lines 1 through 3
No entry. These fields fill in automatically from MH 1901 Schedules B and C.

Line 4 – Cost per Unit
No entry. Starting from Column B, Line 3 is divided by Line 2 for each service function level.

Line 5 – Non-Medi-Cal Units
No entry. Starting from Column B, non-Medi-Cal units for each service function fills in from Line 2.

Line 6
No entry. Starting from Column B, non-Medi-Cal costs for each service function fills in from Line 3.

State of California Health and Human Services Agency — Department of Mental Health

DETAIL COST REPORT

ALLOCATION OF COSTS TO SERVICE FUNCTIONS - MODE TOTAL — PAGE 1 OF 1

MH 1966 (Rev. 7/07) — FISCAL YEAR 2006 - 2007

County: 0
County Code:

Legal Entity: 0		A	B	C	D	E	F	G
Legal Entity Number:			Service	Service	Service	Service	Service	Service
Mode: 45 - Outreach Services		Mode Total	Function	Function	Function	Function	Function	Function
1	Allocation Percentage							
2	Total Units							
3	Gross Cost							
4	Cost per Unit							
5	Non-Medi-Cal Units							
6	Non-Medi-Cal Costs							

MH 1966 Mode 55

Medi-Cal Administrative Activities (MAA)

MH 1966 for Mode 55 is for Medi-Cal Administrative Activities (MAA) and consists of five lines. MH 1966 for Mode 55 automatically populates from MH 1901 Schedules A, B and C. Legal entities must have an approved MAA plan with DMH in order to report Mode 55.

Lines 1 through 3
No entry. These fields fill in automatically from MH 1901 Schedules B and C.

Line 4 – Cost per Unit
No entry. Starting from Column B, Line 3 is divided by Line 2 for each service function level.

Line 5 – Non-Medi-Cal Units
No entry. Starting from Column B, non-Medi-Cal units for each service function fills in by taking Line 3, Column A of this form and subtracting MH 1968, Line 35, Column D.

State of California Health and Human Services Agency — Department of Mental Health

DETAIL COST REPORT

ALLOCATION OF COSTS TO SERVICE FUNCTIONS - MODE TOTAL — PAGE 1 OF 1

MH 1966 (Rev. 7/06) — FISCAL YEAR 2006 - 2007

County: 0
County Code:

Legal Entity: 0		A	B	C	D	E	F	G
Legal Entity Number:			Service	Service	Service	Service	Service	Service
Mode: 55 - Medi-Cal Administrative Activities		Mode Total	Function	Function	Function	Function	Function	Function
1	Allocation Percentage							
2	Total Units							
3	Total Expenditures							
4	Cost per Unit							
5	Non-Medi-Cal Costs							

MH 1968

Determination of SD/MC Direct Services and MAA Reimbursement

The purpose of MH 1968 is to determine the net SD/MC and Healthy Families direct service reimbursement (FFP and State Match) for inpatient and outpatient services as well as MAA reimbursement. MAA service function expenditures are combined on the MH 1968.

Nominal Fee Provider

Determination of Nominal Fee status is the first step in the cost report settlement process, before application of reimbursement limit (42 CFR 413.13). Legal entities with a significant portion of low-income patients will be required to complete an optional form MH 1969 Nominal Fee Provider Determination prior to completion of MH 1968. Nominal fee providers' reimbursement is limited to the lower of Actual Cost or SMA.

Determination of Cost Settlement Process

Cost settlement process is based on the application of the Lower of Cost or Charges (LCC) cost reimbursement principles. Pursuant to cost reimbursement rules, the application of LCC will be based on the aggregate cost of all outpatient services. Healthy Families follows SD/MC settlement technique and process.

Column K – Total Outpatient
No entry. This column sums Column I – Total Outpatient excluding Program 2 and Column J (Mode 15, Program 2).

Line 1 – Medi-Cal Costs
(July 1, 2006 – September 30, 2006)
No entry. The total cost of providing services to regular (excludes enhanced and Medicare crossovers) Medi-Cal patients for each mode of service in Columns E through H and J fills in automatically from Column A, Line 13 of MH 1966 for the applicable modes. Note that costs reported on Line 1 are for services provided to Medi-Cal patients only and are not gross costs from Line 3 of MH 1966. The sum of Columns F through H calculates automatically in Column I, Line 1 and represents the total outpatient Medi-Cal Costs for Program 1.

Line 1A – Medi-Cal Costs
(October 1, 2006 – June 30, 2007)
No entry. The total cost of providing services to regular (excludes enhanced and Medicare crossovers) Medi-Cal patients for each mode of service in Columns E through H and J fills in automatically from Column A, Line 13A of MH 1966 for the applicable modes. Note that costs reported in Line 1A are for services provided to Medi-Cal patients only and are not gross costs from Line 3 of MH 1966. The sum of Columns F through H calculates automatically in Column I, Line 1A and represents the total outpatient Medi-Cal Costs for Program 1.

Line 2 – Medi-Cal SMA Upper Limits
(July 1, 2006 – September 30, 2006)
No entry. Medi-Cal SMA Upper Limits for each mode of service in Columns E through H and J fills in automatically from Column A, Line 14 of MH 1966 for applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 2.

Line 2A – Medi-Cal SMA Upper Limits
(October 1, 2006 – June 30, 2007)
No entry. Medi-Cal SMA Upper Limits for each mode of service in Columns E through H and J fills in automatically from Column A, Line 14A of MH 1966 for applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 2A.

Line 3 – Medi-Cal Published Charges
(July 1, 2006 – September 30, 2006)
No entry. Medi-Cal Published Charges for each mode of service in Columns E through H and J fills in automatically from Column A, Line 15 of MH 1966 for applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 3.

Line 3A – Medi-Cal Published Charges
(October 1, 2006 – June 30, 2007)
No entry. Medi-Cal Published Charges for each mode of service in Columns E through H and J fills in automatically from Column A, Line 15A of MH 1966 for applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 3A.

Line 4 – Medi-Cal Negotiated Rates
(July 1, 2006 – September 30, 2006)
If applicable, Medi-Cal Negotiated Rates for each mode of service in Columns E through H and J fills in automatically from Column A, Line 16 of MH 1966 for applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 4.

State of California Health and Human Services Agency — Department of Mental Health

DETAIL COST REPORT

DETERMINATION OF SD/MC DIRECT SERVICES AND MAA REIMBURSEMENT

MH 1968 (Rev. 7/06) — FISCAL YEAR 2006 - 2007

County: 0
County Code:
Legal Entity: 0
Legal Entity Number:

			REIMBURSEMENT TYPE				PC	PC				Costs	
			A	B	C	D	E	F	G	H	I	J	K
			Mode 55			Total MAA	Total Inpatient				Total Outpatient Exclude Program (2)		Total Outpatient (Col. I + Col. J)
			S. F.'s 01-09	S. F.'s 11-19, 31-39	S. F.'s 21-29		Mode 05 Hospital Inpatient Services	Mode 05 Other 24 Hour Services	Mode 10 Day Services	Mode 15 Outpatient Services Program (1)		Mode 15 Outpatient Services Program (2)	
1	Medi-Cal Costs	07/01/06 - 09/30/06											
1A		10/01/06 - 06/30/07											
2	Medi-Cal SMA	07/01/06 - 09/30/06											
2A		10/01/06 - 06/30/07											
3	Medi-Cal P. C.	07/01/06 - 09/30/06											
3A		10/01/06 - 06/30/07											
4	Medi-Cal N. R.	07/01/06 - 09/30/06											
4A		10/01/06 - 06/30/07											
5	Medi-Cal Gross Reimbursement	07/01/06 - 09/30/06											
5A		10/01/06 - 06/30/07											
6	Medicare/Medi-Cal Crossover Cost	07/01/06 - 09/30/06											
6A		10/01/06 - 06/30/07											
7	Medicare/Medi-Cal Crossover SMA	07/01/06 - 09/30/06											
7A		10/01/06 - 06/30/07											
8	Medicare/Medi-Cal Crossover P. C.	07/01/06 - 09/30/06											
8A		10/01/06 - 06/30/07											
9	Medicare/Medi-Cal Crossover N. R.	07/01/06 - 09/30/06											
9A		10/01/06 - 06/30/07											
10	Medicare/Medi-Cal Crossover Gross Reim.	07/01/06 - 09/30/06											
10A		10/01/06 - 06/30/07											
11	Total SD/MC + Crossover Gross Reim.	07/01/06 - 09/30/06											
11A		10/01/06 - 06/30/07											
12	Enhanced SD/MC (Children) Cost	07/01/06 - 09/30/06											
12A		10/01/06 - 06/30/07											
13	Enhanced SD/MC (Children) SMA	07/01/06 - 09/30/06											
13A		10/01/06 - 06/30/07											
14	Enhanced SD/MC (Children) P. C.	07/01/06 - 09/30/06											
14A		10/01/06 - 06/30/07											
15	Enhanced SD/MC (Children) N. R.	07/01/06 - 09/30/06											
15A		10/01/06 - 06/30/07											
16	Enhanced SD/MC (Children) Gross Reim.	07/01/06 - 09/30/06											
16A		10/01/06 - 06/30/07											
17	Enhanced SD/MC (Refugees) Cost	07/01/06 - 06/30/07											
18	Enhanced SD/MC (Refugees) SMA	07/01/06 - 06/30/07											
19	Enhanced SD/MC (Refugees) P. C.	07/01/06 - 06/30/07											
20	Enhanced SD/MC (Refugees) N. R.	07/01/06 - 06/30/07											
21	Total Medi-Cal Gross Reimbursement	07/01/06 - 09/30/06											
21A	(Excludes Refugees)	10/01/06 - 06/30/07											
22	Enhanced SD/MC (Refugees) Gross Reim.	07/01/06 - 06/30/07											
23	Healthy Families Cost	07/01/06 - 09/30/06											
23A		10/01/06 - 06/30/07											
24	Healthy Families SMA	07/01/06 - 09/30/06											
24A		10/01/06 - 06/30/07											
25	Healthy Families P. C.	07/01/06 - 09/30/06											
25A		10/01/06 - 06/30/07											
26	Healthy Families N. R.	07/01/06 - 09/30/06											
26A		10/01/06 - 06/30/07											
27	Healthy Families Gross Reim.	07/01/06 - 09/30/06											
27A		10/01/06 - 06/30/07											
	Less: Patient and Other Payor Revenue												
28	SD/MC + Crossover Revenue	07/01/06 - 09/30/06											
28A		10/01/06 - 06/30/07											
29	Enhanced SD/MC (Children) Revenue												
30	Enhanced SD/MC (Refugees) Revenue												
31	Healthy Families Revenue												
32	Total Expenditures from MAA (Mode 55)												
33	Medi-Cal Eligibility Factor (Average)												
34	Revenue - MAA												
35	Net Due - SD/MC for Direct Services	07/01/06 - 09/30/06											
35A		10/01/06 - 06/30/07											
36	Net Due - Enhanced SD/MC (Refugees)												
37	Net Due - Healthy Families	07/01/06 - 09/30/06											
37A		10/01/06 - 06/30/07											
	Amount Negotiated Rates Exceed Costs												
38	SD/MC (Includes Children)	07/01/06 - 09/30/06											
38A		10/01/06 - 06/30/07											
39	Enhanced SD/MC (Refugees)												
40	Healthy Families	07/01/06 - 09/30/06											
40A		10/01/06 - 06/30/07											

HOME Goto MH1969

Line 4A – Medi-Cal Negotiated Rates
(October 1, 2006 – June 30, 2007)
If applicable, Medi-Cal Negotiated Rates for each mode of service in Columns E through H and J fills in automatically from Column A, Line 16A of MH 1966 for applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 4A.

Line 5 – Medi-Cal Gross Reimbursement
(July 1, 2006 – September 30, 2006)
Legal entities fall into one of four categories based on type of reimbursement system and qualification as nominal fee providers. Table 1 represents the four categories of legal entities and lines from MH 1968 that should be compared. Automatically, the lowest amount from lines being compared is selected and entered on this line. Inpatient reimbursement and Outpatient reimbursement methods are determined independently in Columns E and I. Column J consists of Program 2 costs that are to be reimbursed to the county at actual cost as long as the aggregate cost per unit of service is below the SMA. Column J for this line is automatically computed by taking the lower of the Cost line or the SMA line (see Table 2).

Line 5A – Medi-Cal Gross Reimbursement
(October 1, 2006 – June 30, 2007)
Legal entities fall into one of four categories based on type of reimbursement system and qualification as nominal fee providers. Table 1 represents the four categories of legal entities and lines from MH 1968 that should be compared. Automatically, the lowest amount from lines being compared is selected and entered on this line. Inpatient reimbursement and Outpatient reimbursement methods are determined independently in Columns E and I. Column J consists of Program 2 costs that are to be reimbursed to the county at actual cost as long as the aggregate cost per unit of service is below the SMA. Column J for this line is automatically computed by taking the lower of the Cost line or the SMA line (see Table 2).

Table 1
Lines for Comparison

Legal Entity Classifications	Reimbursement Method	Lowest of Lines
Cost-Based Reimbursement		
1. Nominal Fee Provider	Cost - or - SMA	1 + 1A + 6 + 6A + 12 + 12A + 17 - or - 2 + 2A + 7 + 7A + 13 + 13A + 18
2. Not A Nominal Fee Provider	Cost - or - SMA - or - Published Charges	1 + 1A + 6 + 6A + 12 + 12A + 17 - or - 2 + 2A + 7 + 7A + 13 + 13A + 18 - or - 3 + 3A + 8 + 8A + 14 + 14A + 19
Negotiated Rate Reimbursement		
3. Nominal Fee Provider	SMA - or - Negotiated Rates	2 + 2A + 7 + 7A + 13 + 13A + 18 - or - 4 + 4A + 9 + 9A + 15 + 15A + 20
4. Not a Nominal Fee Provider	SMA - or - Published Charges - or - Negotiated Rates	2 + 2A + 7 + 7A + 13 + 13A + 18 - or - 3 + 3A + 8 + 8A + 14 + 14A + 19 - or - 4 + 4A + 9 + 9A + 15 + 15A + 20

Line 6 – Medicare/Medi-Cal Crossover Costs
(July 1, 2006 – September 30, 2006)
No entry. The total cost of providing services to Medicare/Medi-Cal crossover patients for each mode of service in Columns E through H and J fills in automatically from Column A, Line 17 of MH 1966 for applicable modes. The sum of Columns F through H is automatically calculated in Column I, Line 6.

Line 6A – Medicare/Medi-Cal Crossover Costs
(October 1, 2006 – June 30, 2007)
No entry. The total cost of providing services to Medicare/Medi-Cal crossover patients for each mode of service in Columns E through H and J fills in automatically from Column A, Line 17A of MH 1966 for applicable modes. The sum of Columns F through H is automatically calculated in Column I, Line 6A.

Line 7 – Medicare/Medi-Cal Crossover SMA
(July 1, 2006 – September 30, 2006)
No entry. Medi-Cal SMA Upper Limit amounts for Medicare/Medi-Cal crossover patients for each mode of service in Columns E through H and J fills in automatically from Column A, Line 18 of MH 1966 for applicable modes. The sum of Columns F through H is automatically calculated in Column I, Line 7.

Line 7A – Medicare/Medi-Cal Crossover SMA
(October 1, 2006 – June 30, 2007)
No entry. Medi-Cal SMA Upper Limit amounts for Medicare/Medi-Cal crossover patients for each mode of service in Columns E through H and J fills in automatically from Column A, Line 18A of MH 1966 for applicable modes. The sum of Columns F through H is automatically calculated in Column I, Line 7A.

Line 8 – Medicare/Medi-Cal Crossover Published Charges
(July 1, 2006 – September 30, 2006)
No entry. Medicare/Medi-Cal crossover published charge amounts for each mode of service in Columns E through H fills in automatically from Column A, Line 19 of MH 1966 for applicable modes. The sum of Columns F through H is automatically calculated in Column I, Line 8.

Line 8A – Medicare/Medi-Cal Crossover Published Charges
(October 1, 2006 – June 30, 2007)
No entry. Medicare/Medi-Cal crossover published charge amounts for each mode of service in Columns E through H fills in automatically from Column A, Line 19A of MH 1966 for applicable modes. The sum of Columns F through H is automatically calculated in Column I, Line 8A.

Line 9 – Medicare/Medi-Cal Crossover Negotiated Rates
(July 1, 2006 – September 30, 2006)
No entry. If applicable, Medi-Cal Negotiated Rate amounts for Medicare/Medi-Cal crossover patients for each mode of service in Columns E through H fills in automatically from Column A, Line 20 of MH 1966 for applicable modes. The sum of Columns F through H is automatically calculated in Column I, Line 9.

Line 9A – Medicare/Medi-Cal Crossover Negotiated Rates
(October 1, 2006 – June 30, 2007)
No entry. If applicable, Medi-Cal Negotiated Rate amounts for Medicare/Medi-Cal crossover patients for each mode of service in Columns E through H fills in automatically from Column A, Line 20A of MH 1966 for applicable modes. The sum of Columns F through H is automatically calculated in Column I, Line 9A.

Line 10 – Medicare/Medi-Cal Crossover Gross Reimbursement
(July 1, 2006 – September 30, 2006)
No entry. Automatically, the lowest amount from lines (in Table 1) being compared is selected and entered on this line. Inpatient reimbursement and Outpatient reimbursement methods are determined independently in Columns E and I. Column J is automatically computed by taking the lower of the cost line or the SMA line (see Table 2).

Line 10A – Medicare/Medi-Cal Crossover Gross Reimbursement
(October 1, 2006 – June 30, 2007)
No entry. Automatically, the lowest amount from lines (in Table 1) being compared is selected and entered on this line. Inpatient reimbursement and Outpatient reimbursement methods are determined independently in Columns E and I. Column J is automatically computed by taking the lower of the cost line or the SMA line (see Table 2).

Table 2
Lines for Comparison
For Outpatient Program 2 Only

Legal Entity Classifications	Reimbursement Method	Lowest of Lines
All Program 2	Cost	1 + 1A + 6 + 6A + 12 + 12A + 17
	- or -	- or -
	SMA	2 + 2A + 7 + 7A + 13 + 13A + 18

Line 11 – Total SD/MC + Crossover Gross Reimbursement
(July 1, 2006 – September 30, 2006)
No entry. Automatically fills in the sum of Lines 5 and 10 in Columns E through K.

Line 11A – Total SD/MC + Crossover Gross Reimbursement
(October 1, 2006 – June 30, 2007)
No entry. Automatically fills in the sum of Lines 5A and 10A in Columns E through K.

Line 12 – Enhanced SD/MC (Children) Cost
(July 1, 2006 – September 30, 2006)
No entry. The total cost of providing services to Enhanced SD/MC (Children) services for each mode of service in Columns E through H and J fills in automatically from Column A, Line 21 of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 21 and represents the total outpatient Medi-Cal Costs for Program 1.

Line 12A – Enhanced SD/MC (Children) Cost
(October 1, 2006 – June 30, 2007)
No entry. The total cost of providing services to Enhanced SD/MC (Children) services for each mode of service in Columns E through H and J fills in automatically from Column A, Line 21A of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 21A and represents the total outpatient Medi-Cal Costs for Program 1.

Line 13 – Enhanced SD/MC (Children) SMA
(July 1, 2006 – September 30, 2006)
No entry. The total SMA Upper Limit cost of providing services to Enhanced SD/MC (Children) services for each mode of service in Columns E through H and J fills in automatically from Column A, Line 22 of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 13 and represents the total outpatient Medi-Cal Costs for Program 1.

Line 13A – Enhanced SD/MC (Children) SMA
(October 1, 2006 – June 30, 2007)
No entry. The total SMA Upper Limit cost of providing services to Enhanced SD/MC (Children) services for each mode of service in Columns E through H and J fills in automatically from Column A, Line 22A of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 13A and represents the total outpatient Medi-Cal Costs for Program 1.

Line 14 – Enhanced SD/MC (Children) Published Charges
(July 1, 2006 – September 30, 2006)
No entry. The total published charge cost of providing services to Enhanced SD/MC (Children) services for each mode of service in Columns E through H and J fills in automatically from Column A, Line 23 of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 14 and represents the total outpatient Medi-Cal Costs for Program 1.

Line 14A – Enhanced SD/MC (Children) Published Charges
(October 1, 2006 – June 30, 2007)
No entry. The total published charge cost of providing services to Enhanced SD/MC (Children) services for each mode of service in Columns E through H and J fills in automatically from Column A, Line 23A of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 14A and represents the total outpatient Medi-Cal Costs for Program 1.

Line 15 – Enhanced SD/MC (Children) Negotiated Rate
(July 1, 2006 – September 30, 2006)
No entry. The total negotiated rate cost of providing services to Enhanced SD/MC (Children) services for each mode of service in Columns E through H and J fills in automatically from Column A, Line 24 of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 15 and represents the total outpatient Medi-Cal Costs for Program 1.

Line 15A – Enhanced SD/MC (Children) Negotiated Rate
(October 1, 2006 – June 30, 2007)
No entry. The total negotiated rate cost of providing services to Enhanced SD/MC (Children) services for each mode of service in Columns E through H, and J automatically populates Column A, Line 24A of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 15A and represents the total outpatient Medi-Cal Costs for Program 1.

Line 16 – Enhanced SD/MC (Children) Gross Reimbursement
(July 1, 2006 – September 30, 2006)
No entry. Automatically, the lowest amount from lines (in Table 1) being compared is selected and entered on this line. Inpatient reimbursement and Outpatient reimbursement methods are determined independently in Columns E through I. Column J is automatically computed by taking the lower of the cost line or the SMA line (see Table 2).

Line 16A – Enhanced SD/MC (Children) Gross Reimbursement
(October 1, 2006 – June 30, 2007)
No entry. Automatically, the lowest amount from lines (in Table 1) being compared is selected and entered on this line. Inpatient reimbursement and Outpatient reimbursement methods are determined independently in Columns E through I. Column J is automatically computed by taking the lower of the cost line or the SMA line (see Table 2).

Line 17 – Enhanced SD/MC (Refugees) Cost
(July 1, 2006 – June 30, 2007)
No entry. The total cost of providing services to Enhanced SD/MC (Refugees) services for each mode of service in Columns E through H and J fills in automatically from Column A, Line 25 of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 17 and represents the total outpatient Medi-Cal Costs for Program 1.

Line 18 – Enhanced SD/MC (Refugees) SMA
(July 1, 2006 – June 30, 2007)
No entry. The total SMA cost of providing services to Enhanced SD/MC (Refugees) services for each mode of service in Columns E through H and J fills in automatically from Column A, Line 26 of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 18 and represents the total outpatient Medi-Cal Costs for Program 1.

Line 19 – Enhanced SD/MC (Refugees) Published Charge
(July 1, 2006 – June 30, 2007)
No entry. The total published charge cost of providing services to Enhanced SD/MC (Refugees) services for each mode of service in Columns E through H, and J fills in automatically from Column A, Line 27 of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 19 and represents the total outpatient Medi-Cal Costs for Program 1.

Line 20 – Enhanced SD/MC (Refugees) Negotiated Rate
(July 1, 2006 – June 30, 2007)
No entry. The total negotiated rate cost of providing services to Enhanced SD/MC (Refugees) services for each mode of service in Columns E through H and J fills in automatically from Column A, Line 28 of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 20 and represents the total outpatient Medi-Cal Costs for Program 1.

Line 21 – Total Medi-Cal Gross Reimbursement (excludes Enhanced SD/MC Refugees)
(July 1, 2006 – September 30, 2006)
No entry. This is automatically calculated as the sum of Lines 11 and 16. The total Medi-Cal Gross Reimbursement for SD/MC (Refugees) is accounted for in Line 22 (see below).

Line 21A – Total Medi-Cal Gross Reimbursement (excludes Enhanced SD/MC Refugees)
(October 1, 2006 – June 30, 2007)
No entry. This is automatically calculated as the sum of Lines 11A and 16A. The total Medi-Cal Gross Reimbursement for SD/MC (Refugees) is accounted for in Line 22 (see below).

Line 22 – Enhanced SD/MC (Refugees) Gross Reimbursement
(July 1, 2006 – June 30, 2007)
No entry. Automatically, the lowest amount from lines (in Table 1) being compared is selected and entered on this line. Inpatient reimbursement and Outpatient reimbursement methods are determined independently in Columns E and I. Column J is automatically computed by taking the lower of the cost line or the SMA line (see Table 2).

Line 23 – Healthy Families Cost
(July 1, 2006 – September 30, 2006)
No entry. The total cost of providing services to Healthy Families for each mode of service in Columns E through H and J fills in automatically from Column A, Line 29 of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 23 and represents the total outpatient Healthy Families Costs for Program 1.

Line 23A – Healthy Families Cost
(October 1, 2006 – June 30, 2007)
No entry. The total cost of providing services to Healthy Families for each mode of service in Columns E through H, and J fills in automatically from Column A, Line 29A of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 23A and represents the total outpatient Healthy Families Costs for Program 1.

Line 24 – Healthy Families SMA
(July 1, 2006 – September 30, 2006)
No entry. The total SMA cost of providing services to Healthy Families for each mode of service in Columns E through H and J fills in automatically from Column A, Line 30 of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 24 and represents the total outpatient Healthy Families Costs for Program 1.

Line 24A – Healthy Families SMA
(October 1, 2006 – June 30, 2007)
No entry. The total SMA cost of providing services to Healthy Families for each mode of service in Columns E through H and J fills in automatically from Column A, Line 30A of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 24A and represents the total outpatient Healthy Families Costs for Program 1.

Line 25 – Healthy Families Published Charge
(July 1, 2006 – September 30, 2006)
No entry. The total published charge cost of providing services to Healthy Families for each mode of service in Columns E through H and J fills in automatically from Column A, Line 31 of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 25 and represents the total outpatient Healthy Families Costs for Program 1.

Line 25A – Healthy Families Published Charge
(October 1, 2006 – June 30, 2007)
No entry. The total published charge cost of providing services to Healthy Families for each mode of service in Columns E through H and J fills in automatically from Column A, Line 31A of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 25A and represents the total outpatient Healthy Families Costs for Program 1.

Line 26 – Healthy Families Negotiated Rate
(July 1, 2006 – September 30, 2006)
No entry. The total negotiated rate cost of providing services to Healthy Families for each mode of service in Columns E through H and J fills in automatically from Column A, Line 32 of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 26 and represents the total outpatient Healthy Families Costs for Program 1.

Line 26A – Healthy Families Negotiated Rate
(October 1, 2006 – June 30, 2007)
No entry. The total negotiated rate cost of providing services to Healthy Families for each mode of service in Columns E through H and J fills in automatically from Column A, Line 32A of MH 1966 for the applicable modes. The sum of Columns F through H calculates automatically in Column I, Line 26A and represents the total outpatient Healthy Families Costs for Program 1.

Line 27 – Healthy Families Gross Reimbursement
(July 1, 2006 – September 30, 2006)
No entry. Automatically, the reimbursement method selected by comparing the lowest amount from lines in Tables 1 and 2 for all SD/MC costs is utilized to apply the same methodology to determine Healthy Families Gross Reimbursement. Inpatient reimbursement and Outpatient reimbursement methods are determined independently in Columns E and I. Column J is automatically computed by taking the lower of the cost line or the SMA line (see Table 2).

Line 27A – Healthy Families Gross Reimbursement
(October 1, 2006 – June 30, 2007)
No entry. Automatically, the reimbursement method selected by comparing the lowest amount from lines in Tables 1 and 2 for all SD/MC costs is utilized to apply the same methodology to determine Healthy Families Gross Reimbursement. Inpatient reimbursement and Outpatient reimbursement are determined independently in Columns E and I. Column J is automatically computed by taking the lower of the cost line or the SMA line (see Table 2).

Line 28 – Less: Patient and Other Payor Revenues
(July 1, 2006 – September 30, 2006)
No entry. Revenue such as patient fees for Medi-Cal share of costs, patient insurance, Medicare, and other revenues received on behalf of Medi-Cal clients in providing Medi-Cal units reported on MH 1966 automatically populate from MH 1901 Schedule B, Columns K and L. This does not include realignment funding. Revenues should be reported on an accrual basis and should be identified as directly as possible to service function or mode level. If revenues cannot be directly identified, use a reasonable method to allocate revenues between inpatient and outpatient services.

Medicare revenues include revenues for services provided during this cost report fiscal year. *Prior year* Medicare revenues *should not* be included in the cost report.

Line 28A – Less: Patient and Other Payor Revenues
(October 1, 2006 – June 30, 2007)
No entry. The amounts are automatically populated from MH 1901 Schedule B, Column L. See Line 28 for more information.

Line 29 – Enhanced SD/MC (Children) Patient Revenue
No entry. The amounts are automatically populated from MH 1901 Schedule B, Column O. See Line 28 for more information.

Line 30 – Enhanced SD/MC (Refugees) Patient Revenue
No entry. The amounts are automatically populated from MH 1901 Schedule B, Column Q. See Line 28 for more information.

Line 31 – Healthy Families Patient Revenue
No entry. Healthy Families client fees, or other sources for providing services to Healthy Families clients, are automatically populated from MH 1901 Schedule B, Column T. See Line 28 for more information.

Line 32 – Total Expenditures from MAA (Mode 55)
No entry. Total Expenditures identified in MH 1966, Mode 55, Line 3 for Service Functions 1 through 9 in Column A; Service Functions 11 through 19 and 31 through 39 in Column B; and Service Functions 21 through 29 in Column C automatically populate these fields. The sum of Columns A, B and C automatically calculates in Column D.

Line 33 – Medi-Cal Eligibility Factor (Average)
No entry. County Medi-Cal eligibility factor (percentage) cell references MH 1901 Schedule A, Column E, Line 35.

Line 34 – Revenue – MAA
No entry. Does not apply.

Line 35 – Net Due SD/MC for Direct Services
(July 1, 2006 – September 30, 2006)
No entry. Column A automatically populates the amount from Line 32.
Columns B and C are filled by the result of product of Lines 32 and 33. The sum of Columns A, B and C, Line 35, is automatically populated in Column D, Line 35.

For Columns E, I, J and K, the result of Line 21 minus the sum of Lines 28 and 29 is automatically populated.

Line 35A – Net Due SD/MC for Direct Services
(October 1, 2006 – June 30, 2007)
No entry. The result of Line 21A minus Lines 28A for Columns E, I, J and K are automatically populated.

Line 36 – Net Due Enhanced SD/MC (Refugees)
No entry. The result of Line 22 minus Line 30 for Columns E, I, J and K are automatically populated.

Line 37 – Net Due for Healthy Families
(July 1, 2006 – September 30, 2006)
No entry. The result of Line 27 minus Line 31 in Columns E, I, J and K are automatically populated.

Line 37A – Net Due for Healthy Families
(October 1, 2006 – June 30, 2007)
No entry. Line 27A is automatically populated here.

Line 38 – Amount Negotiated Rates Exceed Costs for SD/MC (Excludes Enhanced SD/MC Refugees)
(July 1, 2006 – September 30, 2006)
No entry. The difference of the sum of Lines 4, 9 and 15 minus the sum of Lines 1, 6 and 12 is automatically populated here. If the difference is less than zero, then zero is automatically populated. This line excludes enhanced SD/MC (Refugees) and INCLUDES enhanced SD/MC (Children).

Line 38A – Amount Negotiated Rates Exceed Costs for SD/MC (Excludes Enhanced SD/MC Refugees)
(October 1, 2006 – June 30, 2007)
No entry. The difference of the sum of Lines 4A, 9A and 15A minus the sum of Lines 1A, 6A and 12A is automatically populated here. If the difference is less than zero, then zero is automatically populated here. This line excludes Enhanced SD/MC (Refugees) and INCLUDES Enhanced SD/MC (Children).

Line 39 – Amount Negotiated Rates Exceed Costs for Enhanced SD/MC (Refugees)
No entry. The difference of Line 20 minus Line 17 is automatically populated here.
If the difference is less than zero, then zero is automatically populated.

Line 40 – Amount Negotiated Rates Exceed Costs for Healthy Families (July 1, 2006 – September 30, 2006)
No entry. The difference of Line 26 minus Line 23 is automatically populated here.
If the difference is less than zero, then zero is automatically populated.

Line 40A – Amount Negotiated Rates Exceed Costs for Healthy Families (October 1, 2006 – June 30, 2007)
No entry. The difference of Line 26A minus Line 23A is automatically populated here.
If the difference is less than zero, then zero is automatically populated.

MH 1969 INST

Instructions for Lower of Costs or Charges Determination

The purpose of MH 1969 INST is to determine if you qualify as a Nominal Fee Provider. Before you can continue to complete the MH 1969, you must answer four questions on MH 1969 INST.

- ☐ Does your legal entity have a published schedule of its full (non-discounted) charges?
- ☐ Are your legal entity's revenues for patient care based on application of a published charge schedule?
- ☐ Does your legal entity maintain written policies for its process of making patient indigence determinations?
- ☐ Does your legal entity maintain sufficient documentation to support the amount of "indigence allowances" written off in accordance with the above procedures?

Nominal Fee Provider determination
Please answer the following questions.

Yes	No		
☑	☐	1.	Does your legal entity have a published schedule of its full (non-discounted) charges?
☑	☐	2.	Are your legal entity's revenue for patient care based on application of published charge schedule?
☑	☐	3.	Does your legal entity maintain written policies for its process of making patient indigence determinations?
☑	☐	4.	Does your legal entity maintain sufficient documentation to support the amount of "indigence allowances" written off in accordance with the above procedures?

HOME << MH1960 MH1969 >>

If you answer No to any of the above questions, then you DO NOT qualify as a Nominal Fee Provider and you should not complete the MH 1969.

MH 1969 (Optional)

Lower of Costs or Charges Determination

The legal entity must have a published schedule of its full (non-discounted) charges. The objective of MH 1969 is to determine whether legal entities are exempt from having to apply the Lower of Cost or Charges (LCC) principle. MH 1969 is an optional form and should be completed by legal entities whose charges are lower than the SMA upper limits; and costs for non-negotiated rate legal entities or negotiated rates for negotiated rate legal entities. If a legal entity's Medi-Cal adjusted customary charges are equal to or less than 60 percent of Medi-Cal costs, and the legal entity meets four additional criteria, the legal entity is exempt from having to include charges in the comparison on MH 1968. The four additional criteria that must be met by a legal entity are:

- The legal entity must have a published schedule of its full (non-discounted) charges.
- The legal entity's revenues for patient care must be based on application of a published charge schedule.
- The legal entity must maintain written policies for its process of making patient indigence determinations.
- The legal entity must maintain sufficient documentation to support the amount of "indigence allowances" written off in accordance with the above procedures.

The exemption must be proved separately for Medi-Cal Inpatient Services (Mode 05-Hospital Inpatient Services) and Medi-Cal Outpatient Services (Mode 05-Other 24 Hour Services, Mode 10-Day Services, and Mode 15-Outpatient Services). Refer to DMH Letter No. 90-05 and attachments for a detailed explanation of how to meet these four criteria.

Medi-Cal adjusted customary charges are calculated using several different methods, all of which result in the same outcome.[2] MH 1969 employs the calculation method applicable to most legal entities. Medi-Cal adjusted customary charges are calculated by first dividing actual charges to non-Medicare and non-Medi-Cal patients by adjusted or published charges to non-Medicare and non-Medi-Cal patients. This ratio is then applied to Medi-Cal charges (i.e., amounts billed to Medi-Cal), resulting in Medi-Cal adjusted customary charges. These charges are compared to 60 percent of Medi-Cal costs and, if equal to or less, the legal entity is exempt from having to apply the LCC principle. Dollar amounts should be rounded to the nearest whole dollar.

[2] See: *Medicare and Medicaid Guide*, Commerce Clearing House, ¶7585, August 1989.

State of California Health and Human Services Agency — Department of Mental Health

DETAIL COST REPORT

LOWER OF COSTS OR CHARGES EXEMPTION DETERMINATION (Optional)

MH 1969 (Rev. 7/06) — FISCAL YEAR 2006 - 2007

County: 0
County Code:

Legal Entity: 0
Legal Entity Number:

		A	B	C	D	E
		Total Inpatient				Total Outpatient
		Mode 05 Hospital Inpatient	Mode 05 Other 24 Hour Services	Mode 10 Day Services	Mode 15 Outpatient Services	
1	Amount billed to Medi-Cal					
	Non-Medicare/Medi-Cal Actual Charges					
2	Non-Medicare/Medi-Cal Patient Revenue					
3	Non-Medicare/Medi-Cal Patient Insurance					
4	Subtotal					
5	Non-Medicare/Medi-Cal Published Charges					
6	Ratio of Actual to Published Charges	0.00%				0.00%
7	Medi-Cal Adjusted Customary Charges					
8	Medi-Cal Costs					
9	60 Percent of Medi-Cal Costs					

DMH use only

	Inpatient		Outpatient
Line 9 greater than line 7.		Exempt	
Line 7 greater than line 9.	X	Not Exempt	X

<< MH1969_INST | HOME | Goto MH1968

Line 1 – Amount Billed to Medi-Cal

Enter the amount billed to Medi-Cal (through DMH) for the cost report fiscal year. The amount should be derived from the county's monthly billing records. Enter amount for each mode of service in the appropriate column. The sum of Columns B through D is automatically populated in Column E.

Line 2 – Non-Medicare/Medi-Cal Patient Revenues

Enter the total patient revenue for the cost report fiscal year billed (not necessarily collected) to non-Medicare patients and non-Medi-Cal patients based on the Uniform Method of Determining Ability to Pay (UMDAP). Billings to patients liable for payment on a charge basis (non-contractual patients) based on the UMDAP should be reported.

Billings to Health Maintenance Organization (HMOs), County Organized Health System (COHSs), Preferred Provider Organization (PPOs), or Primary Care Case Management (PCCMs) should not be included. Line 2, Column A, represents amount billed to patients for Mode 05-Hospital Inpatient Services and Line 2, Column E, represents amount billed to patients for Mode 05-Other 24 Hour Services, Mode 10-Day Services, and Mode 15-Outpatient Services.

Line 3 – Non-Medicare/Medi-Cal Patient Insurance
Enter the total patient insurance collected from non-Medicare patients and non-Medi-Cal patients for the cost report fiscal year. Line 3, Column A, represents patient insurance collected for Mode 05-Hospital Inpatient Services and Line 3, Column E, represents patient insurance collected for Mode 05-Other 24 Hour Services, Mode 10-Day Services, and Mode 15-Outpatient Services.

Line 4 – Subtotal
No entry. This line sums Lines 2 and 3 for Column A (Inpatient) and Column E (Outpatient).

Line 5 – Non-Medicare/Medi-Cal Published Charges
Non-Medicare/Medi-Cal Published Charges represent amount non-Medicare and non-Medi-Cal patients would have paid had they been full-fee paying patients. On a separate worksheet maintained by the legal entity, multiply the units of service/time provided to non-Medicare and non-Medi-Cal patients by the legal entity's published charge or rate for each service function. These amounts should be aggregated by mode of service and reported in appropriate Column on Line 5. The sum of Columns B through D is automatically populated in Column E. Columns A and E represent legal entity's non-Medicare/Medi-Cal published charges for inpatient and outpatient services.

Line 6 – Ratio of Actual to Published Charges
No entry. The calculation is Line 4 divided by Line 5 in Column A (Inpatient) and Column E (Outpatient).

Line 7 – Medi-Cal Adjusted Customary Charges
No entry. The calculation is Line 1 multiplied by Line 6 in Column A (Inpatient) and Column E (Outpatient).

Line 8 – Medi-Cal Costs
No entry. The legal entity's total cost for providing Medi-Cal Inpatient and Outpatient services are automatically populated in Columns A and E. These costs are derived from the sum of MH 1968, Lines 11, 11A, 16, 16A and 22, Column E and Column I.

Line 9 – 60 Percent of Medi-Cal Costs
No entry. Columns A and E are automatically calculated by multiplying Line 8 by 60 percent and the results automatically populate Line 9.

If amount on Line 9, Column A (60 percent of Medi-Cal inpatient costs) is greater than Line 7, Column A (Medi-Cal inpatient adjusted customary charges), the legal entity is exempt from having to apply the LCC principle for Mode 05-Hospital Inpatient Services. If Line 7, Column A, is greater than Line 9, Column A, the legal entity is not exempt from having to apply the LCC principle for Mode 05-Hospital Inpatient Services on MH 1968, and must include Medi-Cal Mode 05-Hospital Inpatient charges in the comparison on MH 1968.

If amount on Line 9, Column E (60 percent of Medi-Cal outpatient costs) is greater than Line 7, Column E (Medi-Cal outpatient adjusted customary charges), the legal entity is exempt from having to apply the LCC principle for outpatient services. If Line 7, Column E, is greater than Line 9, Column E, the legal entity is not exempt from having to apply the LCC principle for outpatient services on MH 1968, and must include the Medi-Cal outpatient charges in the comparison on MH 1968.

MH 1979

SD/MC Preliminary Desk Settlement

The objective of MH 1979 is to determine the preliminary net Federal Financial Participation (FFP) due to the legal entity for all SD/MC and Healthy Families services. Data for Lines 1 through 10 and 13 through 15 are to be entered by County legal entities on appropriate forms (MH 1900_Information and MH 1960, etc.).

Line 1 – County SD/MC Direct Service Gross Reimbursement
No entry. In Columns B and C, County's legal entity SD/MC Direct Service Gross Reimbursement for inpatient and outpatient services are automatically populated from MH 1968, Columns E and K, sum of Lines 21, 21A and 22. The sum of Columns B and C is automatically populated in Column D.

Line 2 – Contract Provider Medi-Cal Direct Service Gross Reimbursement
No entry. In Columns B and C, Contract Providers SD/MC Direct Service Gross reimbursement for inpatient and outpatient services are automatically populated from the MH 1900 Information Sheet. These services are manually entered on the MH 1900 Information Sheet from the MH 1968, Columns E and K, sum of Lines 21, 21A and 22 for all legal entities that contract for SD/MC services with the county of County Mental Health Plans (MHPs). This entry should include payments to FFS/MC hospitals for psychiatric inpatient services (MH 1994, Lines 2A, 6 and 7 **Plus FFP**) that have not been included in the Allowable Costs for Allocation (Line 8) on MH 1960. The sum of Columns B and C automatically populates in Column D.

Line 3 – Total Medi-Cal Direct Service Gross Reimbursement
No entry. The sum of Lines 1 and 2 in Column D are automatically populated on Line 3. This amount represents total allowable SD/MC direct service costs in the county that will be used to determine maximum allowable SD/MC administrative reimbursement for the county legal entity.

Line 4 – SD/MC Administrative Reimbursement Limit
No entry. SD/MC Administrative costs are limited to 15 percent of SD/MC direct service costs. Column D, Line 3 is automatically multiplied by 0.15 to compute maximum SD/MC reimbursement for administrative services.

Line 5 – SD/MC Administration
No entry. SD/MC administrative costs are automatically populated from MH 1960, Column C, Line 9.

State of California Health and Human Services Agency — Department of Mental Health

DETAIL COST REPORT

SD/MC PRELIMINARY DESK SETTLEMENT

MH 1979 (Rev. 7/06) — FISCAL YEAR 2006 - 2007

County: 0
County Code:

	Legal Entity: 0		A	B	C	D	E	F	G	H	I	J
	Legal Entity Number:		Total MAA	Total Inpatient	Total Outpatient	Total	50.00% FFP	50.00% FFP	50.00% FFP	[1]Variable % FFP	75.00% FFP	Total FFP
	SD/MC Administrative Reimbursement (County Only)											
1	County SD/MC Direct Service Gross Reimbursement											
2	Contract Providers Medi-Cal Direct Service Gross Reimbursement											
3	Total Medi-Cal Direct Service Gross Reimbursement											
4	Medi-Cal Administrative Reimbursement Limit											
5	Medi-Cal Administration											
6	Medi-Cal Administrative Reimbursement											
	Healthy Families Administrative Reimbursement (County Only)											
7	County Healthy Families Direct Service Gross Reimbursement											
7A	Contract Providers Healthy Families Direct Service Gross Reim.											
7B	Total Healthy Families Direct Service Gross Reimbursement											
8	Healthy Families Administrative Reimbursement Limit											
9	Healthy Families Administration											
10	Healthy Families Administrative Reimbursement											
	SD/MC Net Reimbursement for MAA											
11	Medi-Cal Admin. Activities Svc Functions 01 - 09											
12	Medi-Cal Admin. Activities Svc Functions 11 - 19, 31 - 39											
13	Medi-Cal Admin. Activities Svc Functions 21 - 29 (County Only)											
14	Utilization Review-Skilled Prof. Med. Personnel (County Only)											
15	Other SD/MC Utilization Review (County Only)											
16	SD/MC Net Reimbursement for Direct Services	07/01/06 - 09/30/06										
16A		10/01/06 - 06/30/07										
17	Enhanced SD/MC Net Reimb. (Children)	07/01/06 - 09/30/06										
17A		10/01/06 - 06/30/07										
18	Enhanced SD/MC Net Reimb. (Refugees)											
19	Total SD/MC Reimbursement Before Excess FFP											
20	Amount Negotiated Rates Exceed Costs - SD/MC & Enh. SD/MC											
21	Total SD/MC Reimbursement (FFP)											
22	Contract Limitation Adjustment											
23	Adjusted Total SD/MC Reimbursement (FFP)											
24	Healthy Families Net Reimbursement	07/01/06 - 09/30/06										
24A		10/01/06 - 06/30/07										
25	Total Healthy Families Reimbursement Before Excess FFP											
26	Amount Negotiated Rates Exceed Costs - Healthy Families											
27	Total Healthy Families Reimbursement											

STATE SHARE OF SD/MC COST

Line 6: Column D minus Column E	
Line 10: Column D minus Column H	
Line 11: Column D minus Column E	
Line 12: Column D minus Column E	
Line 13: Column D minus Column I	
Line 14: Column D minus Column I	
Line 15: Column D minus Column E	
Line 16: Column D minus Column F	
Line 16A: Column D minus Column G	
Line 17: Column D minus Column H	
Line 17A: Column D minus Column H	
Line 18: Column D minus Column H	
Line 24: Column D minus Column H	
Line 24A: Column D minus Column H	
TOTAL STATE SHARE SD/MC COST	

Line 6 – SD/MC Administrative Reimbursement
No entry. The lower of Lines 4 and 5 is automatically populated in Column D, Line 6. The amount in Column D is automatically multiplied by 50 percent to determine FFP for SD/MC administration. The result is rounded to the nearest whole dollar and entered in Column E.

Line 7 – County Healthy Families Direct Service Gross Reimbursement
No entry. Columns B and C, County's legal entity Healthy Families Direct Service Gross Reimbursement, are automatically populated from MH 1968, Columns E and K, sums of Lines 27 and 27A. The sum of Columns B and C automatically populates Column D.

Line 7A – Contract Provider Healthy Families Direct Service Gross Reimbursement
No entry. Columns B and C, Contract Providers Healthy Families Direct Service Gross Reimbursement for inpatient and outpatient services, are manually entered in the MH 1900 Information Sheet based on the calculations from the MH 1968, Columns E and K, sum of Lines 27 and 27A for all legal entities that contract for Healthy Families services with the county of County Mental Health Plans (MHPs). The sum of Columns B and C automatically populates in Column D.

Line 7B – Total Healthy Families Direct Service Gross Reimbursement
No entry. The sum of Lines 7 and 7A in Column D are automatically populated on Line 7B. This amount represents total allowable Healthy Families direct service costs in the county that will be used to determine maximum allowable Healthy Families administrative reimbursement for the county legal entity.

Line 8 – Healthy Families Administrative Reimbursement Limit
No entry. Healthy Families Administrative costs are limited to 10 percent of Healthy Families direct service gross costs. Column D, Line 7, is automatically multiplied by 10 percent to compute Healthy Families administrative limit.

Line 9 – Healthy Families Administration
No entry. The Healthy Families Administrative costs are automatically populated from Column C, Line 10 of MH 1960.

Line 10 – Healthy Families Administrative Reimbursement
No entry. The lower of Lines 8 and 9 from Column D is automatically selected and populated in Column D, Line 10. The amount in Column D is automatically multiplied by 65 percent to determine the FFP for Healthy Families administrative costs. The result is rounded to the nearest whole dollar and populated on Line 10, Column H.

NOTE: Lines 11 through 13 are for MAA participants only. ***Others Skip to Line 14.***

Line 11 – Medi-Cal Administrative Activities Service Functions 01 - 09
No entry. The Net Due from Medi-Cal for MAA for Service Functions 01 through 09 is automatically populated from Line 35, Column A, of MH 1968 in Columns A and D. The result in Column D is automatically multiplied by 50 percent and entered in Columns E and J. Verify that Line 11 equals or agrees with MH 1979, Line 21, Column J (FFP).

Line 12 – Medi-Cal Administrative Activities Service Functions 11 - 19, 31 - 39
No entry. The Net Due from Medi-Cal for MAA for Service Functions 11 through 19, and 31 through 39 is automatically populated from Line 35, Column B, of MH 1968 in Columns A and D. The result in Column D is automatically multiplied by 50 percent and entered in Columns E and J. Verify that Line 12 agrees with MH 1979, Line 27 (Healthy Families).

Line 13 – Medi-Cal Administrative Activities Service Functions 21 - 29 (County Only)
No entry. The Net Due from Medi-Cal for MAA for Service Functions 21 through 29 is automatically populated from Line 35, Column C, of MH 1968 in Columns A and D. The result in Column D is automatically multiplied by 75 percent and populated in Columns I and J.

Line 14 – Utilization Review – Skilled Professional Medical Personnel (County Only)
No entry. The SD/MC utilization review costs for skilled professional medical personnel are populated from Column C, Line 13 of MH 1960. The result in Column D is automatically multiplied by 75 percent to determine FFP and populated in Columns I and J.

Line 15 – Other SD/MC Utilization Review (County Only)
No entry. The other SD/MC utilization review costs are automatically populated from Column C, Line 14 of MH 1960 in Column D. The result in Column D is automatically multiplied by 50 percent to determine FFP and populated in Columns E and J.

Line 16 – SD/MC Net Reimbursement for Direct Services @ 50% (July 1, 2006 – September 30, 2006)
No entry. The SD/MC direct service net reimbursement for inpatient and outpatient services are automatically populated from Columns E and K, Line 11 of MH 1968 in Columns B and C, respectively. Column D automatically sums Columns B and C. The amount in Column D is automatically multiplied by 50 percent to determine FFP for SD/MC direct services and populated in Columns F and J.

Line 16A – SD/MC Net Reimbursement for Direct Services @ 50%
(October 1, 2006 – June 30, 2007)
No entry. The SD/MC direct service net reimbursement for inpatient and outpatient services are automatically populated from Columns E and K, Line 11A of MH 1968 in Columns B and C, respectively. Column D automatically sums Columns B and C. The amount in Column D is automatically multiplied by 50 percent to determine FFP for SD/MC direct services and populated in Columns G and J.

Line 17 – Enhanced SD/MC Net Reimbursement (Children) @ 65%
(July 1, 2006 – September 30, 2006)
No entry. The Enhanced SD/MC (Children) direct services net reimbursement is automatically populated from Columns E (Inpatient) and K (Outpatient), Line 16 of MH 1968 in Columns B and C, respectively. Column D automatically sums Columns B and C. The amount in Column D is automatically multiplied by 65 percent to determine FFP for Enhanced SD/MC (Children) direct services and populated in Columns H and J.

Line 17A – Enhanced SD/MC Net Reimbursement (Children) @ 65%
(October 1, 2006 – June 30, 2007)
No entry. The Enhanced SD/MC (Children) direct services net reimbursement is automatically populated from Columns E (Inpatient) and K (Outpatient), Line 16A of MH 1968 in Columns B and C, respectively. Column D automatically sums Columns B and C. The amount in Column D is automatically multiplied by 65 percent to determine FFP for Enhanced SD/MC (Children) direct services and populated in Columns H and J.

Line 18 – Enhanced SD/MC Net Reimbursement (Refugees) @ 100%
No entry. The Enhanced SD/MC (Refugees) direct services net reimbursement is automatically populated from Columns E (Inpatient) and K (Outpatient), Line 22 of MH 1968 in Columns B and C, respectively. Column D automatically sums Columns B and C. The amount in Column D is automatically multiplied by 100 percent to determine FFP for Enhanced SD/MC (Refugees) direct services and populated in Columns H and J.

Line 19 – Total SD/MC Reimbursement Before Excess FFP
No entry. The sum of Column J, Lines 6, 11 through 15, 16, 16A, 17, 17A and 18 are automatically populated in Column J.

Line 20 – Amount Negotiated Rates Exceed Costs – SD/MC and Enhanced SD/MC
No entry. Legal entities reimbursed based on negotiated rates must refund to CMS, 25 percent of the amount negotiated rates or reimbursement rates exceed costs. From MH 1968, the sum of Lines 38, 38A and 39 in Columns E (Inpatient) and K (Outpatient) is automatically populated into Columns B and C, respectively. The sum of Columns B and C is automatically populated in Column D. Column J automatically multiplies Column D by 25 percent. This represents the amount of FFP to be repaid to CMS.

Line 21 – Total SD/MC Reimbursement (FFP)
No entry. For Column J, the result of Line 19 minus Line 20 is automatically populated.

Line 22 – Contract Limitation Adjustment
No entry. This line automatically populates from MH 1900 Information Sheet when the county enters an adjustment to Medi-Cal due to contract limitations.

Line 23 – Adjusted Total SD/MC Reimbursement (FFP)
No entry. The result of Line 21 plus Line 22 is automatically populated.

Line 24 – Healthy Families Net Reimbursement @ 65%
(July 1, 2006 – September 30, 2006)
No entry. The amounts (Net Due-Healthy Families) from MH 1968, Line 37, Columns E (Inpatient) and K (Outpatient) are automatically populated in Columns B and C, respectively. The amount in Column D is automatically multiplied by 65 percent to determine FFP for SD/MC Healthy Families direct services and populated in Columns H and J.

Line 24A – Healthy Families Net Reimbursement @ 65%
(October 1, 2006 – June 30, 2007)
No entry. The amounts (Net Due-Healthy Families) from MH 1968, Line 37A, Columns E (Inpatient) and K (Outpatient) are automatically populated in Columns B and C, respectively. The amount in Column D is automatically multiplied by 65 percent to determine FFP for SD/MC Healthy Families direct services and populated in Columns H and J.

Line 25 – Total Healthy Families Reimbursement Before Excess FFP
No entry. The sum of Line 10, Line 24 and Line 24A automatically populates Column J.

Line 26 – Amount Negotiated Rate Exceeds Cost – Healthy Families
No entry. Column B (Inpatient) and Column C (Outpatient) are automatically entered from MH 1968, sum of Line 40 plus Line 40A, Column E (Inpatient) and Column K (Outpatient). The sum of Column B and C automatically populates Column D. Column D is multiplied by 25 percent and automatically populates Column J.

Line 27 – Total Healthy Families Reimbursement

No entry. The difference between Lines 25 and 26 automatically populates Column J.

MH 1991

Calculation of SD/MC (Hospital Administrative Days)

The objective of MH 1991 is to identify amount of Physician and Ancillary costs associated with SD/MC and Healthy Families (SED) Hospital Administrative Days (Mode 05, Service Function 19) for use on the MH 1966.

Column A – Settlement Group
No entry. Settlement groups are provided.

Column B – Provider Number
Enter 4-digit Provider Number.

Column C – SMA Rate
No entry. SMA Rate for FY 2006-2007 is provided for the two periods.

Column D – Period of Service
No entry. Period of service from 07/01/06 through 07/31/06 - $299.80
Period of service from 08/01/06 through 06/30/07 - $310.68

Column E – Administrative Days
Enter number of SD/MC administrative days according to period during which services were provided and by the settlement group the services were rendered during the fiscal year. This column should match the number of Medi-Cal units reported on Schedule B for Mode 05, Service Function 19.

Column F – Subtotal Amount
No entry. This is the result of Column C multiplied by Column E.

Column G – Physician Costs
Enter cost of physician services related to SD/MC Administrative Days for each period and settlement group. (Amounts should be included in total billed to Medi-Cal).

Column H – Ancillary Costs
Enter cost of ancillary services related to SD/MC Administrative Days for each period and settlement group. (Amounts should be included in total billed to Medi-Cal).

Column I – Total Amount
No entry. This is the sum of Columns F, G and H for each period and settlement group.

State of California Health and Human Services Agency — Department of Mental Health

DETAIL COST REPORT

CALCULATION OF SHORT-DOYLE/MEDI-CAL FOR FY 2006 - 2007 HOSPITAL ADMINISTRATIVE DAYS

MH 1991 (Rev. 7/07) — FISCAL YEAR 2006 - 2007

COUNTY NAME:	LEGAL ENTITY	NAME:
COUNTY CODE:		NUMBER:

A	B	C	D	E	F	G	H	I
Settlement Group	PROVIDER NUMBER	SMA RATE	PERIOD OF SERVICE	ADMIN DAYS	SUBTOTAL AMOUNT	PHYSICIAN COSTS	ANCILLARY COSTS	TOTAL AMOUNT
SD/MC		$299.80	07/01/06 - 07/31/06					
		$310.68	08/01/06 - 09/30/06					
		$310.68	10/01/06 - 12/31/06					
		$310.68	01/01/07 - 06/30/07					
							Sub Total:	
Children EMC		$299.80	07/01/06 - 07/31/06					
		$310.68	08/01/06 - 09/30/06					
		$310.68	10/01/06 - 12/31/06					
		$310.68	01/01/07 - 06/30/07					
							Sub Total:	
Refugees EMC		$299.80	07/01/06 - 07/31/06					
		$310.68	08/01/06 - 09/30/06					
		$310.68	10/01/06 - 12/31/06					
		$310.68	01/01/07 - 06/30/07					
							Sub Total:	
Healthy Families		$299.80	07/01/06 - 07/31/06					
		$310.68	08/01/06 - 09/30/06					
		$310.68	10/01/06 - 12/31/06					
		$310.68	01/01/07 - 06/30/07					
							Sub Total:	
				GRAND TOTAL				

HOME ‹‹ MH1901_Schedule_B MH1961 ››

MH 1992 INST

Identification of Funding Sources

The purpose of the MH 1992 INST is to identify all funding sources that are applicable. This form is designed to remove all unnecessary lines from the MH 1992.

"Yes" box will be the automatic default for all Funding Sources for the legal entity.

Identification of Funding Sources Please check all that apply.				
Yes	No		Funding Sources	MH1992
☑	☐	1.	SAMHSA Grants	(Line 4)
☑	☐	2.	PATH Grants	(Line 5)
☑	☐	3.	RWJ Grants	(Line 6)
☑	☐	4.	Other Grants	(Line 7)
☑	☐	5.	Patient Fees	(Line 9)
☑	☐	6.	Patient Insurance	(Line 10)
		7.	Regular SD/MC (FFP only)	(Line 11)
		8.	Healthy Family - Fed share	(Line 12)
☑	☐	9.	Medicare - Fed. Share	(Line 13)
☑	☐	10.	Conservatorship Admin. Fees	(Line 14)
☑	☐	11.	State General Fund-State Share	(Line 15)
☑	☐	12.	State General Fund-County Match	(Line 16)
☑	☐	13.	SGF-Managed Care - Outpatient	(Line 17)
☑	☐	14.	04-05 Rollover - Managed Care-Other	(Line 18)
☑	☐	15.	EPSDT SD/MC - State Share Est.	(Line 19)
☑	☐	16.	04-05 SGF Rollover	(Line 20A)
☑	☐	17.	Other Revenue	(Line 20B)
☑	☐	18.	Realignment Funds/MOE	(Line 21)
☑	☐	19.	Prior Years MHSA	(Line 22)
☑	☐	20	MHSA	(Line 23)
☑	☐	21	County Overmatch	(Line 24)
☑	☐	22	CALWORKS	(Line 25)

HOME MH1992 >>

MH 1992

Funding Sources

The objective of MH 1992 is to identify the types of resources used to finance specific mental health program activities for each legal entity by mode of service. Funding source identifies who is paying for programs authorized by the county mental health agency.

Column J – Total Legal Entity
No entry. This column sums Columns A through I for each line.

Line 1 – Gross Cost
No entry. Column A, Line 1, is the sum of Column C, Lines 12 and 17 of MH 1960. Column B is from MH 1960, Column C, Line 16. Columns C through I, Line 1 are from Column A, Line 3 of the relevant MH 1966's.

Line 2 – Adjustment
Enter in Columns C through I, the amounts needed to adjust legal entity costs to actual program funding, such as the difference between county contract rate and actual cost incurred by contract providers.

State of California Health and Human Services Agency — Department of Mental Health

DETAIL COST REPORT

FUNDING SOURCES

MH 1992 (Rev. 7/07) — FISCAL YEAR 2006 - 2007

County: 0
County Code:

Legal Entity: 0		A	B	C	D	E	F	G	H	I	J	
Legal Entity No.:		Admin./ Research & Evaluation	Utilization Review	Direct Services/MAA: Mode 05 - Hospital Inpatient	Mode 05 - Other 24 Hour Services	Mode 10 - Day Services	Mode 15 - Outpatient Services	Mode 45 - Outreach Services	Mode 55 - MAA	Mode 60 - Support Services	Total Legal Entity	
1	Gross Cost											CROSSCHECKS
2	Adjustments											
3	Adjusted Gross Cost											OK

For Legal Entities that provide services to *multiple counties,* adjust gross aggregate county legal entity allowable costs on Line 2, Columns C through I to agree with the amount received from each county for which a cost report is being submitted. Report aggregate gross county legal entity costs for all county legal entities on MH 1960, and aggregate gross county legal entities units of service on MH 1901 Schedule B for the determination of cost per unit.

Line 3 – Adjusted Gross Cost
No entry. Line 1 plus or minus Line 2 is automatically populated.

Line 4 – SAMHSA Grants
Enter revenues expended from SAMHSA grants for appropriate modes of service.

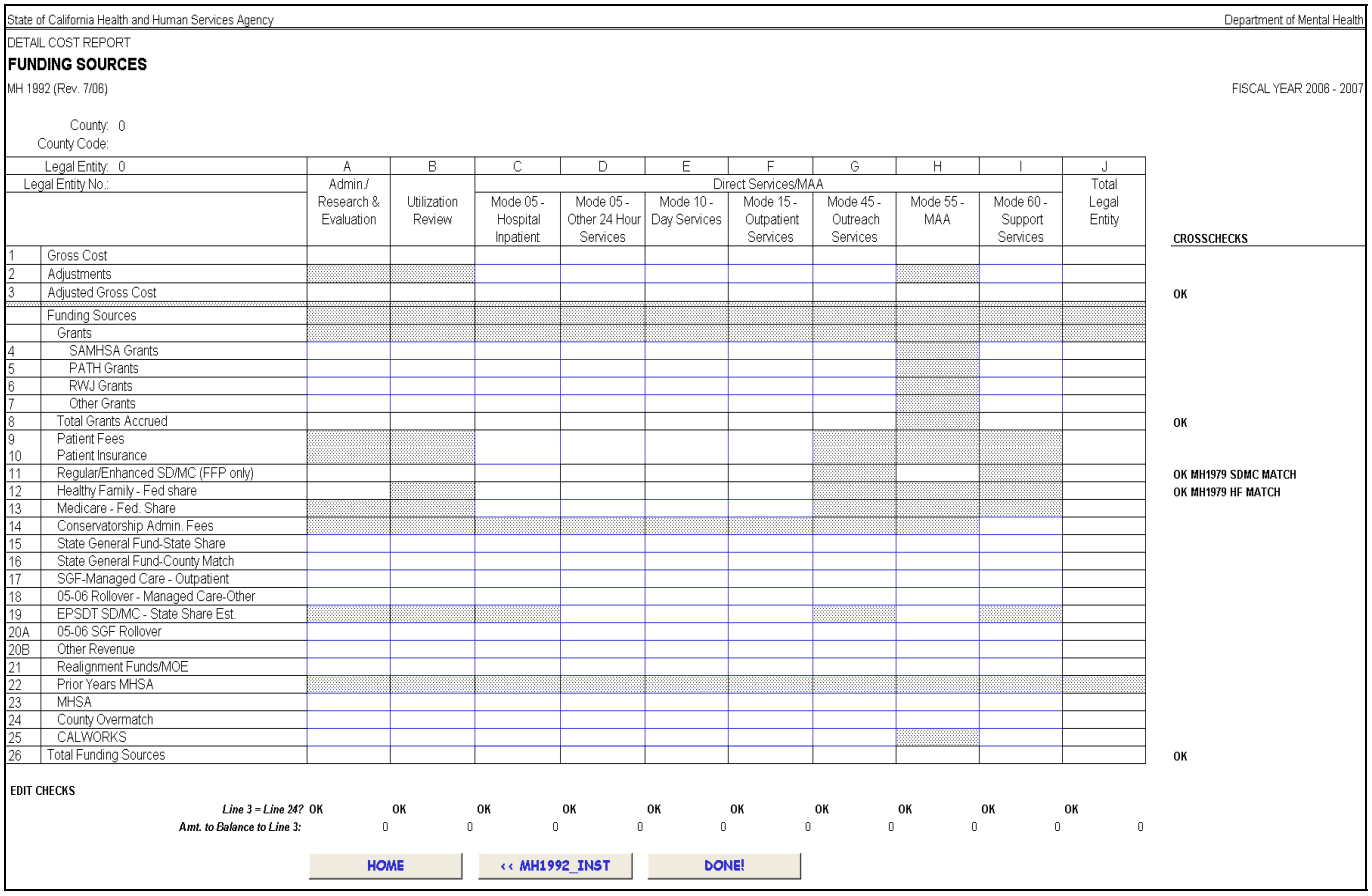
Line 5 – PATH Grants
Enter revenues expended from PATH grants for appropriate modes of service.

Line 6 – RWJ Grants
Enter revenues expended from Robert Wood Johnson (RWJ) Foundation grants for appropriate modes of service.

Line 7 – Other Grants
Enter revenues expended from other grants not reported on Lines 4 through 6 for appropriate modes of service.

Line 8 – Total Grants Accrued
No entry. Lines 4 through 7 for Columns A through G are automatically populated.

Line 9 – Patient Fees
Enter patient fees received for appropriate treatment program modes of service.



State of California Health and Human Services Agency — Department of Mental Health

DETAIL COST REPORT

FUNDING SOURCES

MH 1992 (Rev. 7/06) — FISCAL YEAR 2006 - 2007

County: 0
County Code:

	Legal Entity: 0	A	B	C	D	E	F	G	H	I	J	
	Legal Entity No.:	Admin./ Research & Evaluation	Utilization Review	Direct Services/MAA Mode 05 - Hospital Inpatient	Mode 05 - Other 24 Hour Services	Mode 10 - Day Services	Mode 15 - Outpatient Services	Mode 45 - Outreach Services	Mode 55 - MAA	Mode 60 - Support Services	Total Legal Entity	CROSSCHECKS
1	Gross Cost											
2	Adjustments											
3	Adjusted Gross Cost											OK
	Funding Sources											
	Grants											
4	SAMHSA Grants											
5	PATH Grants											
6	RWJ Grants											
7	Other Grants											
8	Total Grants Accrued											OK
9	Patient Fees											
10	Patient Insurance											
11	Regular/Enhanced SD/MC (FFP only)											OK MH1979 SDMC MATCH
12	Healthy Family - Fed share											OK MH1979 HF MATCH
13	Medicare - Fed. Share											
14	Conservatorship Admin. Fees											
15	State General Fund-State Share											
16	State General Fund-County Match											
17	SGF-Managed Care - Outpatient											
18	05-06 Rollover - Managed Care-Other											
19	EPSDT SD/MC - State Share Est.											
20A	05-06 SGF Rollover											
20B	Other Revenue											
21	Realignment Funds/MOE											
22	Prior Years MHSA											
23	MHSA											
24	County Overmatch											
25	CALWORKS											
26	Total Funding Sources											OK

EDIT CHECKS

Line 3 = Line 24?	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK
Amt. to Balance to Line 3:		0	0	0	0	0	0	0	0	0

HOME | << MH1992_INST | DONE!

Line 10 – Patient Insurance
Enter patient insurance received for appropriate treatment program modes of service.

Line 11 – Regular and Enhanced SD/MC (FFP Only)
No entry. SD/MC and Enhanced SD/MC net reimbursement (FFP portion only) are included on this line. Column A (Administration) comes from MH 1979, Column J, Line 6. Column B (Utilization Review) is the result of MH 1979, Column J, Lines 14 plus 15. Column C (Mode 05 – Hospital Inpatient) is the result of MH 1979, Column B, sum of Line 16 x .50, plus Line 16A x .50, plus Line 17 x .65, plus Line 17A x .65, plus Line 18 x 1.00, minus MH 1979, Column B, Line 20 x .25. Columns D (Mode 05 – Other 24 Hour Services), E (Mode 10 – Day Services) and F (Mode 15 – Outpatient Services) are calculated using data from MH 1968, Columns F (Mode 05- Other 24 Hour Services), G (Mode 10 – Day Services), and H plus J (Mode 15 – Outpatient Services, Programs 1 and 2), Line 11 minus Line 28, x .50, plus Line 11A minus Line 28A, x .50, plus Line 16 minus Line 29, x .65, plus Line 16A, x .65, plus Line 22 minus Line 30, x 1.0 minus the sum of Lines 38, 38A and 39 x .25. Column H (Mode 55 – MAA) is calculated using MH 1979, Column J, sum of Lines 11, 12 and 13.

Line 12 – Healthy Families – Federal Share
No entry. Column A (Administration) comes from MH 1979, Column J, Line 10. Column C (Mode 05 – Hospital Inpatient) is the result of MH 1979, Column B, Line 24 x .65, plus Line 24A x .65, minus the product of .25 x Line 26. Columns D (Mode 05 – Other 24 Hour Services), E (Mode 10 – Day Services) and F (Mode 15 – Outpatient Services) are calculated using data from MH 1968, Columns F (Mode 05 – Other 24 Hour Services), G (Mode 10 – Day Services) and H plus J (Mode 15 – Outpatient Services, Programs 1 and 2), Line 37 x .65, plus Line 37A x .65, minus .25 x sum of Lines 40 plus 40A.

Line 13 – Medicare – Federal Share
Enter Medicare revenue accrued/received for appropriate treatment program modes of service.

Line 14 – Conservator Administrative Fees
Enter conservator administration fees received in Column I, Line 14.

Line 15 – State General Fund – State Share
Enter State share of State General Fund (SGF) (90 percent for large counties) in Columns A through I. These are primarily categorical funds allocated by DMH to the counties for FY 2006-2007. Community Services – Other Treatment for Mental Health Managed Care should not be included on this line. Total amount should equal MH 1940, Column A, Lines 9, 10, 11 and 12.

Line 16 – State General Fund – County Match
Enter county share (10 percent for large counties) of cost to match State General Fund in Columns A through I, if applicable.

Line 17 – State General Fund – Managed Care – Outpatient Mental Health Services
Enter expenditures by modes of service for Outpatient Mental Health Services funded by FY 2006-2007 SGF – Managed Care allocation. Total amount should equal MH 1994, Lines 8 and 9 and MH 1940, Line 13, Column A.

Line 18 – FY 2005-2006 Rollover – Managed Care – Outpatient Mental Health Services
Enter expenditures for Outpatient Mental Health Services by modes of service, funded by rollover from FY 2005-2006 SGF – Managed Care allocation. The amount should equal MH 1994, Line 2B, amount expended on Outpatient Mental Health Services. Line 2A is inpatient hospital expenditures paid from the contingency reserves, while Line 2B is outpatient expenditures paid also from the contingency reserves.

Line 19 – EPSDT SD/MC – State Share Estimate
Enter estimated SGF of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) SD/MC. Estimated amount should be based upon anticipated EPSDT expenditures and may or may not be different than EPSDT SGF Interim Funding the County received as an advance. EPSDT amount should be reflected on MH 1940, Line 16.

Line 20A – FY 2005-2006 SGF Rollover
Enter by mode of service, categorical funds SGF rolled over from the previous fiscal year.

NOTE: Report county match for rollover that requires county share.

Line 20B – Other Revenues
Enter here all other revenues received and not reported on Lines 4 through 19.

Line 21 – Realignment Funds/Maintenance of Effort
Enter amount expended per realignment funding and county Maintenance of Effort (MOE) obligations pursuant to Welfare and Institutions Code § 17608.05 for each mode of service. Include realignment funds used to match FFP under the SD/MC program. Exclude realignment funding for State Hospitals and county match for SGF allocated by State Department of Mental Health.

Line 22 – Prior Years-MHSA
No entry. Field Shaded for FY 2006-2007.

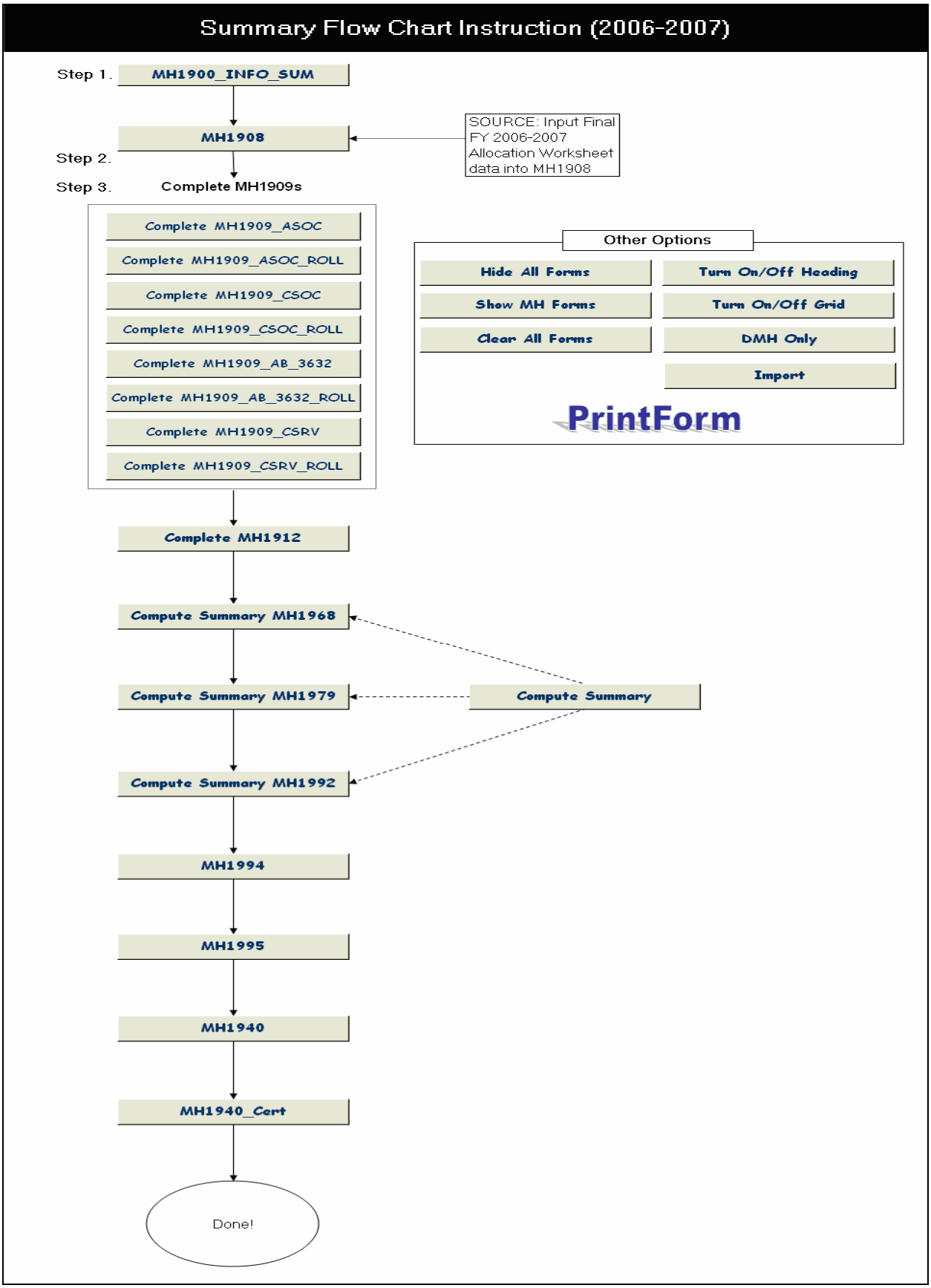
Line 23 – MHSA
Enter amount expended per MHSA funding, including MHSA funds used to match FFP under the SD/MC program. This amount should equal MH 1995, Line 7.

Line 24 – County Overmatch
Enter county overmatch funds the county contributes over the percentage amounts prescribed by law.

Line 25 – CalWORKS
Enter the county CalWORKS funds used for mental health services.

Line 26 – Total Funding Sources
No entry. This line sums Lines 8 through 25 for Columns A through I. Amount in Column J, Line 25, should equal amount in Column J, Line 3. Any difference between the two amounts should be corrected before submitting the cost report.

No text on this page..


Summary Flow Chart Instruction (2006-2007)
Step 1.
MH1900_INFO_SUM
MH1908
SOURCE: Input Final FY 2006-2007 Allocation Worksheet data into MH1908
Step 2.
Step 3.
Complete MH1909s
Complete MH1909_ASOC
Complete MH1909_ASOC_ROLL
Complete MH1909_CSOC
Complete MH1909_CSOC_ROLL
Complete MH1909_AB_3632
Complete MH1909_AB_3632_ROLL
Complete MH1909_CSRV
Complete MH1909_CSRV_ROLL
Other Options
Hide All Forms
Turn On/Off Heading
Show MH Forms
Turn On/Off Grid
Clear All Forms
DMH Only
Import
PrintForm
Complete MH1912
Compute Summary MH1968
Compute Summary MH1979
Compute Summary
Compute Summary MH1992
MH1994
MH1995
MH1940
MH1940_Cert
Done!

Summary Forms for Counties ONLY

This section details the following forms and their requirements for Summary County Cost Reporting ONLY.

MH 1900_INFO_SUM	Information Sheet (Sample in Appendix D)
MH 1908	Supplemental State Resource Data Report final amounts for State Categorical Funds from “Final Allocation” Letter
MH 1909	Supplemental Cost Report Data by Program Category
MH 1909_SUM	Supplemental Cost Report Data by Program Category (Sample in Appendix D)
MH 1912	Supplemental Cost Report Data for Special Education Program
MH 1968_SUM	Determination of SD/MC Direct Service and MAA Reimbursement (Sample in Appendix D)
MH 1979_SUM	Summary SD/MC Preliminary Desk Settlement (Sample in Appendix D)
MH 1992_SUM	Summary Funding Sources (Sample in Appendix D)
MH 1994	Report of Mental Health Managed Care Allocation and Expenditures
MH 1995	Report of Mental Health Services Act (MHSA) Distribution and Expenditures
MH 1940 and Certification Page	Year End Cost Report Summary
MH 1979_1992_RECON	Reconciliation of MH 1979 and MH 1992 for FFP Accuracy (Sample in Appendix D)
MH_EPSDT	EPSDT Costs (Sample in Appendix D)
MHINOUT	Inpatient/Outpatient Summary (Sample in Appendix D)
MH 1992DETAIL	MH 1992 Detail (Sample in Appendix D)

MH 1908

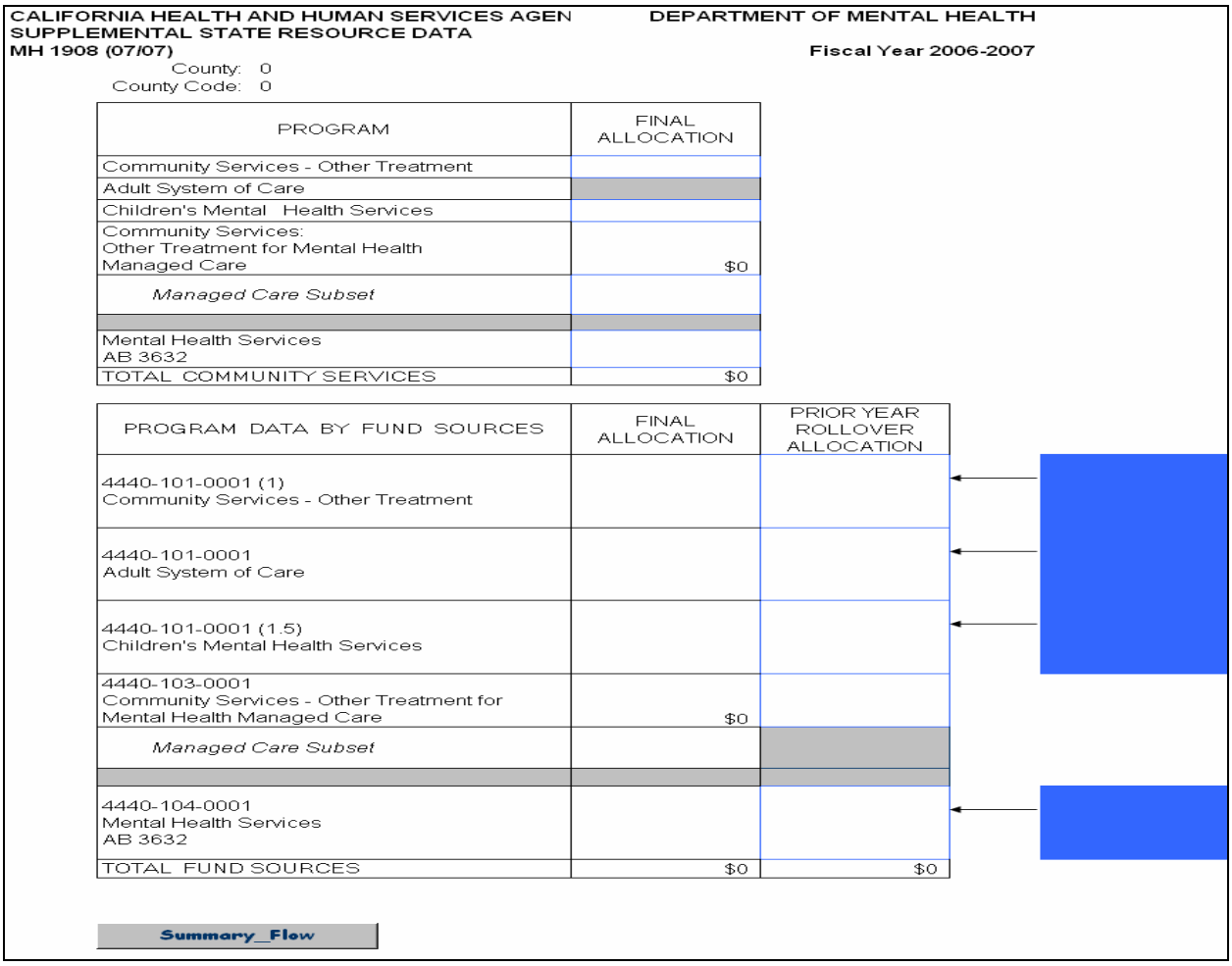
Supplemental State Resource Data – Preliminary Worksheet to the MH 1909s

The purpose of the MH 1908 Supplemental State Resource Data worksheet is to identify the final allocation amounts for each program category and to identify the prior year rollover amounts. The data entered here automatically populates the MH 1909's for each program category.

First Table – Program and Final Allocation
Enter county's allocation amount for budget category from the county's Final Allocation Worksheet.

Second Table – Program Data by Fund Sources, Final Allocation and Prior Year Rollover Allocation
The first column is "Final Allocation". This column is automatically populated based on the information in the first table.

The second column is "Prior Year Rollover Allocation". Enter any rollover allocations from FY 2005-2006 by fund source.



CALIFORNIA HEALTH AND HUMAN SERVICES AGEN DEPARTMENT OF MENTAL HEALTH
SUPPLEMENTAL STATE RESOURCE DATA
MH 1908 (07/07) Fiscal Year 2006-2007
County: 0
County Code: 0

PROGRAM	FINAL ALLOCATION
Community Services - Other Treatment	
Adult System of Care	
Children's Mental Health Services	
Community Services: Other Treatment for Mental Health Managed Care	$0
Managed Care Subset	
Mental Health Services AB 3632	
TOTAL COMMUNITY SERVICES	$0

PROGRAM DATA BY FUND SOURCES	FINAL ALLOCATION	PRIOR YEAR ROLLOVER ALLOCATION
4440-101-0001 (1) Community Services - Other Treatment		
4440-101-0001 Adult System of Care		
4440-101-0001 (1.5) Children's Mental Health Services		
4440-103-0001 Community Services - Other Treatment for Mental Health Managed Care	$0	
Managed Care Subset		
4440-104-0001 Mental Health Services AB 3632		
TOTAL FUND SOURCES	$0	$0

Summary_Flow

COMMENT BOXES TO THE RIGHT OF THE SECOND TABLE

The comment box is designed to be your navigator in the process of completing the MH 1909 forms. If you enter data in the first table, the comment box will prompt and identify the form or forms for you to complete. On the second table, if you entered data on the rollover Column, you will be prompted to complete the identified MH 1909 form.

Community Services – Other Treatment:
Cost Report FYMH 1909_CSRV
Rollover FYMH 1909_CSRV_ROLL

Mental Health Services - AB3632:
Cost Report FYMH 1909_AB3632
Rollover FYMH 1909_AB3632

Adult Systems of Care:
Cost Report FYMH 1909_ASOC
Rollover FYMH 1909_ASOC_ROLL

Children's Mental Health Services:
Cost Report FYMH 1909_CSOC
Rollover FYMH 1909_CSOC_ROLL

MH 1909

Supplemental Cost Report Data by Program Category

The objective of MH 1909 is to identify State General Fund (SGF) allocation and expenditures for specified budget item and program category funds. A separate MH 1909 is to be prepared for each program category fund and each program category fund rolled over from the previous fiscal year. Rollover expenditures are not current year Categorical Funds Allocation and should not be included in the Funding Sources portion of MH 1940.

Lines 1, 2, 3 – County Name, FY, Submission Date
No entry. The information is pulled from MH 1900_INFO_SUM.

Lines 4 and 5 – Budget Category, Budget Item Number
No entry. The information is hard coded to the individual worksheets.

Line 6 – SGF Allocation
No entry. This amount is pulled from MH 1908 from the second table and the Final Allocation Column.

Column A – Legal Entity Name
No entry. Each legal entity supported by appropriate Budget Program Category being reported. The legal entity name will be pulled from the MH 1900 Information Sheet the moment the legal entity number is entered.

Column B – Legal Entity Number
Enter five-digit number as assigned to Legal Entity.

Column C – Mode of Service
Enter two-digit code for appropriate Mode of Service.

Column D – Service Function
Enter two-digit code for appropriate Service Function.

Column E – Units of Service
Enter the Units of Service.

Column F – State Share of Net Cost
For each legal entity entry, enter the amount of allocated SGF expended on specified Budget Program Category, excluding amounts used as state match to FFP, which are included in Column G.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
SUPPLEMENTAL COST REPORT DATA BY PROGRAM CATEGORY
MH 1909_CSOC (07/07)

DEPARTMENT OF MENTAL HEALTH

Fiscal Year 2006-2007

Add Line

1) COUNTY NAME 0	2) FISCAL YEAR 2006-2007	3) DATE COMPLETED
4) BUDGET PROGRAM CATEGORY Children's Mental Health Services	5) BUDGET ITEM NUMBER 4440-101-0001 (1.5)	6) ALLOCATION AMOUNT

A	B	C	D	E	F	G	H	J	K
7) LEGAL ENTITY NAME:	Legal Entity Number	Mode of Service	Service Function	Units of Service	State Share of Net Cost	Medi-Cal/ State Share	State General Fund Total	Medi-Cal FFP Share	Other Fund Sources
							$		
							$		
							$		
							$		
							$		
							$		
							$		
							$		
							$		
							$		
							$		
							$		
							$		
							$		
							$		
							$		
							$		
							$		
							$		
							$		
							$		
8) TOTAL STATE GENERAL FUNDS					$	$	$		
9) ADDITIONAL FUNDS								$	$

Footnotes:

Column G – Medi-Cal/State Share

For each legal entity entry, enter the amount of SGF used as state share to the SD/MC FFP generated by the specified Budget Program Category services.

Column H – State General Fund Total

No entry. This is the sum of Columns F and G. This amount should not exceed total SGF allocated for specified Budget Program Category on Final Allocation Worksheet.

Column I – No County Matching Funds for FY 2006-2007

There is no county share of cost requirement to match SGF for counties with populations over 125,000 for FY 2006-2007.

Column J – Medi-Cal/FFP Share

Enter the amount of SD/MC FFP (match) generated by Budget Program Category services specified in Column G ***plus*** additional FFP share matched by other funds in Column K. Entry on Column J must also be reported on MH 1940, Column B.

Column K – Other Fund Sources

Enter expenditures above the allocated SGF used to provide identified Budget Program Category services. This column should also include non-state general funds used to match FFP. However, for CSOC/EPSDT funds, this column can be above allocated SGF even if total allocated fund has not been expended. Please add an explanation line if above the allocated SGF amount. Other funds, such as the IDEA fund, should be reported in this column.

MH 1912

Supplemental Cost Report Data for Special Education Program (SEP)

The objective of MH 1912 is to identify total SEP costs, regardless of funding source. The MH 1912 SEP will be used for reporting total program costs associated with the SEP mandate to the California Legislature and the California Department of Education (CDE). Additionally, for those counties submitting SB 90 Claims for this program, the MH 1912 SEP will be the supporting documentation for that claim.

Lines 1, 2, 3 – County Name, FY, Submission Date
No entry. The information is pulled from MH 1900_INFO_SUM.

Lines 4 and 5 – Budget Category, Budget Item Number
No entry. No information required at this time.

Line 6 – SGF Allocation
No entry. No information required at this time.

Column A – Legal Entity Name
No entry. This field is automatically populated when the Legal Entity Number is identified in Column B.

Column B – Legal Entity Number
Enter the five-digit number assigned to the legal entity, regardless of funding source.

Column C – Mode of Service
Enter the two-digit code for the appropriate Mode of Service.

Column D – Service Function
Enter the two-digit code for the appropriate Service Function.

Columns E through G – Units of Service
Units of Service are for services associated with the AB 3632 SEP program, regardless of funding source. AB 3632 services are only those services on the Individualized Education Plan (IEP). Any other service provided to an AB 3632 eligible child should not be included on the MH 1912 SEP. AB 3632 services begin with the mental health assessment after referral from the Local Education Agency pursuant to the IEP. Any pre-referral services are not considered AB 3632 services and should not be reported on the MH 1912 SEP. The total units of service should match the total units of service reported to CSI and identified as being part of an IEP for SEP. For Medi-Cal legal entities, the total units of service should match the SD/MC approved units of service provided to SEP clients.

Column E – Medi-Cal Units of Service
Enter the Medi-Cal Units of Service for the mode and service function for AB 3632 services.

Column F – Non-Medi-Cal Units of Service
Enter the Non-Medi-Cal Units of Service for the mode and service function for AB 3632 services.

Column G – Total Units of Service
No entry. This is the sum of Medi-Cal Units of Service (Column E) and Non-Medi-Cal Units of Service (Column F). Column G is the Total Units of Service associated with the provision of AB 3632 SEP, regardless of funding source.

Column H –Reimbursement Rate and Cost Per Unit
Enter on separate lines the reimbursement rate for Medi-Cal units used to determine FFP, and the cost per unit for Non-Medi-Cal units by mode and service function from the appropriate MH 1966, Lines 4 through 7.

Column I – Medi-Cal Costs – Total
No entry. This is the sum of Medi-Cal Units of Service (Column E) multiplied by Cost Per Unit (Column H).

Column J – Medi-Cal Costs – FFP
Enter the Medi-Cal FFP Costs for AB 3632 services for each legal entity and service function by multiplying the Total Medi-Cal Costs (Column I) by the FFP sharing ratio. This automatically populates the MH 1940, Line 12, Column B.

Column K – Medi-Cal Costs – County EPSDT Baseline
Enter the estimated county EPSDT baseline funds to be used as match for the FFP in Column J. This represents the amount of county EPSDT baseline funding related to AB 3632 services provided to Medi-Cal beneficiaries.

Column L – Medi-Cal Costs – EPSDT County Match for Growth
Enter the estimated EPSDT county matching funds for the growth in EPSDT State General Funds. This represents the amount of the required ten percent county match to growth in EPSDT SGF for AB 3632 services provided to Medi-Cal beneficiaries.

Column M – Medi-Cal Costs – EPSDT State General Funds
No entry. This is automatically populated from Medi-Cal Costs – Total (Column I) less the sum of Medi-Cal Costs – FFP (Column J), Medi-Cal Costs – EPSDT Baseline (Column K), and Medi-Cal Costs – EPSDT County Match for Growth (Column L). This represents the amount of EPSDT SGF for AB 3632 services provided to Medi-Cal beneficiaries.

Column N – Non-Medi-Cal Costs – Total
No entry. This is the sum of Non-Medi-Cal Units of Service (Column F) multiplied by the Cost Per Unit (Column H).

Column O – Non-Medi-Cal Costs – County Matching Funds
There is no match requirement in FY 2006-07 for AB 3632. However, if county general funds are used to support the SEP program, enter the amount of County General Funds used. Document this in the 'Footnote' section, if this amount is included in the SB 90 claim.

Column P – Non-Medi-Cal Costs – State General Funds
Enter the amount of SGF used to support SEP Non-Medi-Cal Units of Service.

Column Q – Non-Medi-Cal Costs – Other Fund Sources
No entry. This is automatically calculated as the difference between the Total Non-Medi-Cal Costs (Column N) and the funding identified in Non-Medi-Cal Costs – County Matching Funds (Column O) and Non-Medi-Cal Costs – SGF (Column P). This should represent any other funds used to provide service for this program, such as County Office of Education/Special Education Local Plan Areas, realignment funds, patient fees, or any other fund source not identified in any of the other columns. A total amount for each fund source is to be provided in the 'Footnotes' section.

Column R – Total SEP Program Costs
No entry. This is automatically calculated as the Total Units of Service (Column G) multiplied by the Cost per Unit (Column H). This amount should also equal the sum of Total Medi-Cal Cost (Column I) and Non-Medi-Cal Cost (Column N).

NOTE: If other categorical program funds were used to support SEP costs, an explanation in the 'Footnotes' section is required. A copy of the County SB 90 claim for SEP is to be provided to confirm that total costs are included in both documents. Documentation in the 'Footnote' section is required if no County SB 90 claim is filed for SEP.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
SUPPLEMENTAL COST REPORT DATA FOR SPECIAL EDUCATION PROGRAM
MH1912 (07/07)

DEPARTMENT OF MENTAL HEALTH

Fiscal Year 2006-2007

Add Line

1) COUNTY NAME	2) FISCAL YEAR	3) DATE COMPLETED
0	2006-2007	
4) BUDGET PROGRAM CATEGORY	5) BUDGET ITEM NUMBER	6) ALLOCATION AMOUNT

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
				Units of Service				Medi-Cal Costs					Non-Medi-Cal Costs				
7) LEGAL ENTITY NAME:	Legal Entity Number	Mode of Service	Service Function	Medi-Cal	Non-Medi-Cal	Total	Reimburse Rate / Cost per Unit	Total	FFP	County EPSDT Baseline	EPSDT County Match for Growth	EPSDT State General Funds	Total	County Matching Funds	State General Funds	Other Fund Sources	Total SEP Program Costs
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
								$				$	$			$	$
8) TOTAL								$	$	$	$	$	$	$	$	$	$
9) TOTAL STATE GENERAL FUNDS												$			$		$

Footnotes:

MH 1994

Report of Mental Health Managed Care Allocation and Expenditures

The purpose of this form is to allow each county legal entity to report expenditures for Managed Care SGF allocation (4440-103-0001: Community Services – Outpatient Mental Health Services for Mental Health Managed Care).

FY 2005-2006 Rollover – Column A:
Line 1, FY 2005-2006 SGF Mental Health Contingency Reserve
No entry. This amount automatically populated from the MH 1908 Supplemental State Resource Data sheet (Column E, Row 20). This amount represents Managed Care SGF for FY 2005-2006 not spent during that fiscal year and reserved for FY 2006-2007. (This line should be the same as FY 2005-2006 Cost Report, MH 1994, Line 10.)

Line 2a, FY 2005-2006 Contingency Reserve Expenditures for Inpatient Expenditures in FY 2006-2007
Enter FY 2005-2006 Managed Care Contingency Reserve SGF Inpatient expended during FY 2006-2007.

Line 2b, FY 2005-2006 Contingency Reserve Expenditures for Outpatient Expenditures in FY 2006-2007.
Enter FY 2005-2006 Managed Care Contingency Reserve SGF Outpatient expended during FY 2006-2007.

Line 3, SGF Mental Health Contingency Reserve
No entry. Line 1 minus Line 2.

FY 2006-2007 Allocation – Column A:
Line 4, SGF Managed Care Allocation
No entry. This line is automatically populated from MH 1908 Supplemental State Resource Data sheet, 4440-103-0001 “Community Services – Outpatient Mental Health Services for Mental Health Managed Care”.

Line 5, SGF Mental Health Contingency Reserve Rollover Expenditures
No entry. This line picks up from Line 3.

Line 6, FFS/MC Expenditures Acute Inpatient Hospital Days
Enter SGF portion of FFS/MC expenditures for Acute Psychiatric Inpatient Hospital days.

Line 7, FFS/MC Expenditures Inpatient Hospital Administrative Days
Enter SGF portion of FFS/MC expenditures for Inpatient Hospital Administrative days.

Line 8, FFS/MC Expenditures Outpatient Mental Health Services

Enter the expenditures for Managed Care SGF allocation used to match FFS/MC expended for Outpatient Mental Health Services.

Line 9, State General Fund Expenditures Other Mental Health Services

Enter the portion of FY 2006-2007 Managed Care SGF allocation used to fund Other Mental Health Services expenditures.

Line 10, State General Fund Mental Health Contingency Reserve

Enter portion of FY 2006-2007 Managed Care SGF allocation that was not expended during the FY 2006-2007 and is held as contingency reserve to be rolled over for expenditure during FY 2007-2008.

Line 11, Unexpended/Uncommitted State General Fund Balance

No entry. This line sums Lines 4 through 9. The amount listed on this line is the amount that the county identifies as unexpended during FY 2006-2007 and does not intend to rollover into FY 2007-2008.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY — DEPARTMENT OF MENTAL HEALTH

REPORT OF MENTAL HEALTH MANAGED CARE
ALLOCATION AND EXPENDITURES
MH 1994 (07/07) — Fiscal Year 2006-2007

COUNTY OF: 0
COUNTY CODE: 0
DATE COMPLETED:

		A State General Fund
	FY 2005-2006 Rollover	
1)	FY 2005-2006 SGF Mental Health Contingency Reserve	0
2a)	Less FY 2005-2006 Contingency Reserve Expenditures for Inpatient Hospital Services in FY 2006-2007	
2b)	Less FY 2005-2006 Contingency Reserve Expenditures for Outpatient Mental Health Services in FY 2006-2007	
3)	Total SGF Mental Health Contingency Reserve	0
	FY 2006-2007 Allocation	
4)	FY 2006-2007 SGF Managed Care Allocation	0
5)	Plus FY 2005-2006 SGF Mental Health Contingency Reserve Rollover Expenditures (Line 3)	0
6)	Less FY 2006-2007 FFS/MC Expenditures Acute Inpatient Hospital Days	
7)	Less FY 2006-2007 FFS/MC Expenditures Inpatient Hospital Administrative Days	
8)	Less FY 2006-2007 FFS/MC Expenditures Outpatient Mental Health Services	
9)	Less Other FY 2006-2007 State General Fund Expenditures Other Mental Health Services	
10)	Less FY 2006-2007 State General Fund Mental Health Contingency Reserve	
11)	Total FY 2006-2007 Unexpended/Uncommitted State General Fund Balance	0

Summary_Flow

MH 1995

Report of Mental Health Services Act (MHSA) Distribution and Expenditures

The purpose of this form is to allow each county legal entity to report expenditures for MHSA distribution.

Prior Years Distribution – Column A:
Line 1, Prior Years Unexpended Mental Health Services Act Balance
Enter the distribution amount balance received for the MHSA for FY 2005-2006.

Line 2, Prior Years Mental Health Services Act Expenditures
No Entry. (Field shaded for FY 2006-2007.)

Line 3, Prior Years Unexpended Mental Health Services Act Balance
No entry. This line sums Lines 1 and 2. The amount listed on this line is the amount that the county identifies as unexpended MHSA Balance.

FY 2006-2007 Distribution – Column A:
Line 4, FY 2006-2007 Mental Health Services Act Distribution
Enter the distribution amount received for the MHSA for FY 2006-2007.

Line 5, FY 2006-2007 Interest Earned on Mental Health Services Act
Enter Interest earned on MHSA Distribution for the FY 2006-2007.

Line 6, FY 2006-2007 Mental Health Services Act Balance
No entry. This line picks up from Line 3.

Line 7, FY 2006-2007 Mental Health Services Act Expenditures
Enter MHSA expenditures in FY 2006-2007.

Line 8, FY 2006-2007 Unexpended Mental Health Services Act
No entry. The amount listed on this line is the amount that the county identifies as unexpended MHSA during FY 2006-2007.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF MENTAL HEALTH

REPORT OF MENTAL HEALTH SERVICES ACT (MHSA)
DISTRIBUTION AND EXPENDITURES
MH 1995 (07/07) **Fiscal Year 2006-2007**

COUNTY OF: 0
COUNTY CODE: 0
DATE COMPLETED:

Prior Years Balance		A
1)	Prior Years Mental Health Services Act Balance	
2)	Less Prior Years Mental Health Services Act Expenditures	
3)	*Total* *Prior Years Unexpended Mental Health Services Act Balance*	$

FY 2006-2007 Distribution		
4)	FY 2006-2007 Mental Health Services Act Distribution	
5)	Plus: Interest Earned on Mental Health Services Act FY 2006-2007	
6)	Plus: Prior Years Unexpended Mental Health Services Act Balance (Line 3)	$
7)	Less FY 2006-2007 Mental Health Services Act Expenditures	
8)	Total FY 2006-2007 Unexpended Mental Health Services Act Funding	$

4) Enter current year Mental Health Services Act Distribution.
5) Enter Interest Earned on Mental Health Services Act Distribution.
6) No entry, this line is picked up from line 3 above.
7) Enter the amount of Mental Health Services Act expenditures for the current year.
8) Unexpended Mental Health Services Act to be used for future periods.

Summary_Flow

MH 1940

Year End Cost Report

The purpose of this form is to allow each county's local mental health agency to report countywide mental health expenditures and revenues. This form is a summary of cost reports from all legal entities within the county, and information reported is certified by the county's local mental health director and county's auditor-controller as being true and correct. Information on this form is considered local mental health agency's claim for reimbursement and serves as the basis for year-end cost settlement with the State Department of Mental Health. MH 1940's without the appropriate signatures will be considered incomplete.

Column A, Line 1
No entry. Total mental health expenditures and revenues except Medi-Cal, i.e., MH 1992, Column J, Line 3 minus sum of: (a) FFP (MH 1979, Column J, Line 23 plus Line 27); (b) match for FFP (calculated from MH 1979); and (c) MH 1968, Columns E and K, Lines 28, 28A, 29, 30 and 31, for all legal entities.

Column B, Line 1
No entry. Total Medi-Cal related dollars, i.e., sum of: (a) FFP (MH 1979, Column J, Line 23 plus Line 27); (b) match for FFP (calculated from MH 1979); and (c) MH 1968, Columns E and K, Lines 28, 28A, 29, 30 and 31, for all legal entities.

Column C, Line 1
No entry. Sum of Columns A and B, Line 1. This amount should equal total of MH 1992, Line 3, for all legal entities.

Column A, Line 2
No entry. All funding sources except SD/MC (FFP and State Match), SD/MC-related patient and other payor revenues, and SGF (State and County share and Mental Health Managed Care) for all legal entities, plus any categorical funds used as a match for FFP, i.e., MH 1992, Column J, Line 3 minus Lines 11, 12, 15, 16 and 17 minus match for FFP, calculated on the MH 1979 box (located in the lower right hand corner), minus MH 1968, Columns E and K, Lines 28, 28A, 29, 30 and 31, all legal entities, plus amount on MH 1909, Column G, Line 8.

NOTE: If categorical funds (e.g. SEP) were used as a match for FFP amount reflected on MH 1909, Column G, Line 8 is added as part of the calculation for this line.

Column B, Line 2
No entry. Match for FFP plus patient and other payor revenues, i.e., sum of: (a) match for FFP calculated from MH 1979 (shown on list of Information worksheet), and (b) MH 1968, Columns E and K, Lines 28, 28A, 29, 30 and 31, for all legal entities.

Column C, Line 2
No entry. Sum of Columns A and B, Line 2.

Column A, Line 3
No entry. Subtracts Column A, Line 2 from Column A, Line 1.

Column B, Line 3
No entry. Subtracts Column B, Line 2, from Column B, Line 1.

Column C, Line 3
No entry. Sum of Columns A and B, Line 3 or subtraction of Column C, Line 2 from Column C, Line 1.

Column A, Line 4
No entry. County share from MH 1909 Summary.

Column C, Line 4
No entry. Column A, Line 4.

Column A, Line 5
No entry. Subtracts Column A, Line 4 from Column A, Line 3.

Column B, Line 5
No entry. This line is populated from Column B, Line 3. This amount should equal MH 1992, Column J, Line 11 and 12, for all legal entities.

Column C, Line 5
No entry. Subtracts Column C, Line 4 from Column C, Line 3 or sum of Columns A and B, Line 5.

Column A, Line 6
No entry. SGF used as FFP match (from MH 1909 Summary).

Column C, Line 6
No entry. This line is populated from Column A, Line 6.

Column A, Line 7
No entry. Sum of Column A, Line 5 plus Line 6.

Column B, Line 7
No entry. This line is populated from Column B, Line 5. Amount should equal MH 1992, Column J, Lines 11 and 12, for all legal entities.

Column C, Line 7
No entry. Sum of Columns A and B, Line 7 or Column C, Line 5 plus Line 6.

NOTE – Instructions for Lines 9 through 13: Source documents for these figures are FY 2006-2007 Final Allocation Worksheet; MH 1909 Funding Source Summary; MH 1994 Report of Mental Health Managed Care Allocation and Expenditures for FY 2006-2007.

Column A, Line 8
No entry.

Column A, Lines 9 through 11
No entry. Automatically references total SGF expended for each funding source up to the allocated amount from Column H, Line 8.

Column A, Line 12
No entry. This line will be zero.

Column A, Line 13
No entry. Automatically references amount of FY 2006-2007 Community Services – Managed Care allocation spent on "Outpatient Mental Health Services" from MH 1994, Column A, Line 8.

Column B, Line 8
Enter other FFP funds not matched by SGF identified in Lines 9 through 12, Column A.

Column B, Lines 9 through 12
No entry. For each identified Budget Act Line Item Program expenditure (Lines 9 through 12), total FFP matched in part by the SGF in Column A automatically references the appropriate Column cell from MH 1909. The FFP difference between total FFP in Line 7, Column B and the aggregate of Lines 9 through 12 is entered in Line 8, Other Funds.

Column B, Line 13
Justification is required for entry on this line.

Columns A, Line 14
No entry. Amount must equal Column A, Line 7.

Columns B, Line 14
No entry. Amount must equal Column B, Line 7.

Columns A and C, Line 15
No entry. Amount is FY 2006-2007 Community Services – Managed Care allocation spent on Fee-For-Service/Medi-Cal (FFS/MC) Hospital Inpatient Services (i.e., MH 1994, Column A, sum of Lines 6 and 7).

Columns A and C, Line 16
No entry. FY 2006-2007 EPSDT SD/MC – State Share estimate from MH 1992, Column J, Line 19, for all legal entities.

Column C, Lines 8 through 16
No entry. Sum of Columns A and B.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY — DEPARTMENT OF MENTAL HEALTH
YEAR-END COST REPORT
MH 1940 (07/07) — Fiscal Year 2006-2007

COUNTY OF: 0
COUNTY CODE: 0
ADDRESS: 0
0
0
PREPARED BY: 0 PHONE: 0 Date Completed:

FISCAL YEAR ENDING
JUNE 30, 2007

NOTE: AMOUNTS SHOULD BE WHOLE DOLLARS	A STATE GENERAL FUND	B M/C & HF/FED SHARE	C TOTAL	
1. TOTAL EXPENDITURE	$ 0	$ 0	$ 0	OK
2. LESS: REVENUE	(0)	(0)	(0)	
3. SUBTOTAL	0	0	0	
4. LESS: COUNTY SHARE (PER MH 1909)	(0)		(0)	
5. SUBTOTAL NET COUNTY COSTS SUBJECT TO REIMBURSEMENT	0	0	0	OK
6. PLUS: SGF USED AS FFP MATCH (INCLUDED IN LINE 2, COL 2)	0		0	
7. TOTAL NET COUNTY COSTS SUBJECT TO REIMBURSEMENT	$ 0	$ 0	$ 0	
FUNDING SOURCES: 4440-				
8. OTHER FUNDS	0	0	$ 0	
9. 101-0001 (1) COMMUNITY SERVICES - OTHER TREATMENT	0	0	$ 0	
10. 101-0001 ADULT SYSTEM OF CARE	0	0	0	
11. 101-0001 (1.5) CHILDREN'S MENTAL HEALTH SERVICES	0	0	0	
12. 104-0001 MENTAL HEALTH SERVICES AB 3632	0	0	0	
13. 103-0001 COMMUNITY SERVICES - OUTPATIENT FOR MENTAL HEALTH MANAGED CARE	0	0	0	
14. GRAND TOTAL, ALL SOURCES (Must Agree with Line 7)	$ 0	$ 0	$ 0	
15. 103-0001 COMMUNITY SERVICES - INPATIENT FOR MENTAL HEALTH MANAGED CARE	$ 0		$ 0	
16. EPSDT SD/MC - STATE SHARE ESTIMATE	$ 0		$ 0	
Summary_Flow	OK	OK	OK	